VENEREAL

AND

URINARY DISEASES.

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—BY—

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PREFACE TO FIRST EDITION.

At the urgent request of members of the College classes of 1881 and '82, and 1882 and '83, I have consented to the publication of the following pages, which were prepared for my lectures on venereal diseases. As the time devoted to this branch of study in the College curriculum is necessarily short, the lectures were arranged with the idea of presenting the whole subject in as brief a manner as possible; hence, long discussions on many disputed points are entirely omitted. The student and practitioner will, I hope, find that while I have condensed as much as possible all that is said on the subject, that I have not thereby failed to give a clear exposition of the different affections mentioned.

It may be proper to state that I still hold the opinion that there is but one kind of syphilitic virus, producing in the one case a hard chancre, and in the other a soft chancre, and that both these sores may be followed by secondary symptoms.

At the request of my publishers, who claim that a slight resumé of the remedies suitable for urinary disorders is greatly needed, I have added the last few pages.

T. S. Hoyne.

1634 Wabash Avenue, Chicago.

Preface to Second Edition.

The first edition of Venereal and Urinary Diseases has been out of print for a number of years, and it is only after repeated demands from students and physicians that I have carefully revised the volume and furnished the publishers with the sheets.

Many changes and additions have been made in the text, a chapter upon gleet inserted, and the symptoms of the various affections of the kidney added.

It is hoped that the profession will accord the present edition as favorable a reception as the former.

T. S. Hoyne.

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Venereal Diseases.

VENEREAL DISEASES.

Venereal disease is a term used to denote affections arising primarily from sexual intercourse. The word venereal comes from the Latin word *veneris*, meaning that which relates to pleasure. In a more restricted sense, however, the word is considered synonymous with syphilis or syphilitic. Some writers have proposed that those diseases should be called venereal which are produced by excesses in venery, and that the term syphilitic should be applied to those which are the result of impure connection. The custom is to include under the head of venereal all affections arising from sexual intercourse, hence the terms venereal and syphilitic are generally used as synonyms.

The venereal diseases are two, viz.: gonorrhœa and syphilis. The etymology of syphilis is unknown. It may be derived from σύς, a hog, and φιλεο, I love, or from σύν, with, and φιλεο, I love; or from σίφαλος, a reproach, etc. It was supposed by Hunter and other eminent writers that all specific diseases arising from sexual intercourse were due to the same poison which affected different individuals in various ways. These views were, however, incorrect.

Syphilis, in brief, is a specific, infectious disease, acquired only by inheritance, or due in the majority of cases to sexual intercourse, and is communicable by coition, or by the contact of parts that are abraded, or are only lined with a thin epidermis, as the lips, nipples, etc., and is characterized by periods of eruption and periods of repose of variable duration. In fact, the disease may at any time be communicated by the contact of a sound with the secretion from a diseased surface. It is essentially a contagious, virulent disease, of quite regular course, susceptible of cure, but liable to become an heir-loom in the family, and be transmitted to the offspring. It manifests itself in a variety of ways, not always as a special affection, but impresses a peculiar form on all inflammatory diseases which it induces. The earlier symptoms are, as a rule, superficial, the later ones visceral.

The definition just given is incomplete, but is the best that can be given without a thorough classification of all its phases. As a rule, it attacks a person but once, although there are numerous exceptions on record. A subsequent attack is usually much lighter. Syphilis always

makes its first appearance in the form of a chancre, followed sooner or later by a bubo, and perhaps by secondary or so-called constitutional symptoms.

The origin of syphilis is enveloped in great uncertainty. It was formerly claimed that the disease was introduced into Europe from America by Columbus at the end of the fifteenth century, and many hold this opinion at the present day, notwithstanding the fact that a Chinese writer who lived 2637 years before Christ described two kinds of chancres, and gave a full description of the secondary stage. In ancient Hindoo, Arabic, Greek and Latin literature similar descriptions are found. While the Bible does not anywhere give an accurate description of syphilis, we find numerous references to it, *e. g.*, King David complained of sharp pains in his bones. We are satisfied that the disease is not a modern one, and certainly do not as Americans wish to claim the honor (?) of inventors. It is more than probable than in ancient times leprosy and syphilis were confounded, as the former was said to have frequently followed sexual intercourse, and hence in the Bible and elsewhere many symptoms occasioned by the latter were attributed to the former affection.

The progress of syphilis is extremely variable, as well as its duration, being unlimited if not treated skillfully and continuously. But of this we shall speak later.

Nearly all authorities agree that syphilis is growing milder as the ages roll by. It is still a disease difficult to eradicate, chronic in its nature, but far less horrible than it was in the past. Death results in only a minority of cases under the benign treatment of the present age.

The only proper way to study the disease is at the bedside, or face to face, where every little symptom that goes to make up its history can be carefully weighed and compared. No two cases will be found exactly alike in every particular, but all will present a striking similarity. You will find a great many obstacles in the road, even when the patient is desirous of a cure. The diagnosis is not always clear, especially when complicated with other affections; the chancre may not be in sight, but concealed within the urethra; congenital phymosis may obstruct your vision; the patient may be ignorant and unintentionally deceive you, denying the existence of a primary sore which was so insignificant that he thought it of no consequence, or considered it merely an abrasion, or he may shamefully lie to you, thus endeavoring to shield himself from all culpability. In the secondary stage it is not uncommon for patients to deny having had a chancre or primary sore; in chancre about the mouth or secondary ulcerations, when the origin is due to contact of the mouth with the genital organs, seldom is the truth obtained from the patient; neither is it when sodomy has been committed. But by carefully questioning and cross-examining, the physician will finally arrive at the true state of the case.

The disease generally commences in the genital organs, as sexual intercourse is by far the most common cause, and shows itself in the form of a sore of a specific character, and if not immediately arrested, which is not always possible, it invades the lymphatic ganglions of the groin, next the skin and mucous membranes, and lastly, the bones, cartilages and fibrous tissues. It should not be inferred from this that all of these parts are affected at one and the same time, for it is not so (with few exceptions); the essential poison upon which the infection depends lies dormant, so to speak, for a certain length of time, say from four to six weeks, in the tissues in which it has been deposited, limiting its poisonous influences strictly to the genital organs, and sometimes to the lymphatic ganglions of the groin. If the disease is not arrested in this the first stage, in about a month or six weeks, the skin and mucous membranes are affected, as we stated a moment ago, and if still unarrested, in from five to eighteen months, we find the bones, cartilages and fibrous tissues diseased.

For convenience of description, syphilis, the progress of which is regular, is divided into three stages, viz.: primary, secondary and tertiary. There is also another division called the period of incubation; for example, when the syphilitic poison has been innoculated, or been placed in contact with a surface capable of absorption, it gives no evidence of its presence for several days, and then shows itself by induration at the point of innoculation. A similar period of incubation is common in all contagious diseases which involve the purity of the blood.

By primary syphilis we understand that period during which the poison is limited in its action to the genital organs, or to any healthy surface to which it has been brought in contact, manifesting itself in the form of sores and ulcers, called chancres, no matter where they occur. Lymphangitis and adenitis may also be present. By secondary, that the mucous and cutaneous surfaces are affected, only, however, after primary has been known to exist; and by tertiary, that the bones, cartilages, fibrous tissues and internal organs are implicated. Some authors have divided the disease according to time, everything appearing under six months being considered secondary, and every symptom after that time tertiary.

The three stages are usually separated by pauses of greater or less duration, but not invariably, for occasionally patients exhibit signs of all three simultaneously, the stages following one another in very rapid succession. If syphilis is not arrested in the primary stage by proper treatment, which may destroy the syphilitic diathesis, the symptoms always follow in the same order, never skipping any stage, as it was at one time supposed possible by Ricord.

It is definitely settled that syphilis never arises spontaneously, but is always the result of innoculation with a peculiar poison known as the

poison of syphilis or chancre. It never exists without chancre, or a lesion of some sort at the point of entry of the poison, except when hereditary. This primary sore may exist in some unusual situation, where its presence remains undetected and unsuspected as the anus, buccal cavity, etc. Of the precise nature of this poison we are wofully ignorant; we only know it by its effects on the system. It should be stated, however, that Klebs and others suppose that they have discovered what it is, and are now at work trying to demonstrate that it is due to a spore in the blood.

Even at the present time (1893) the results of laboratory investigations are very contradictory, although physicians pretty generally believe that syphilis is due to the presence of a specific microbe found in hard chancres, but not in those of a soft variety. The poison, when brought in contact with a healthy surface, invariably gives rise to a disease similar to itself, the resulting sore or ulcer yielding a virus in every respect identical with that which produced it. The virus reproduces and multiplies itself by a process of zymosis or fermentation; hence syphilis is similar to other zymotic diseases—affections produced by a morbific principle acting on the organism like a ferment. The gravity of the symptoms is not in proportion to the amount of virus absorbed, for the smallest inconceivable atom, perhaps the third potency, when brought in contact with an appropriate surface, is sufficient to fully develop a disease, which, if unarrested, may give rise to fearful results both local and constitutional, leaving a peculiar and distinctive impression upon all the organs and tissues affected, and often affecting the solids and fluids so that the disease is transmissible from parent to child.

The pus from a chancre or other sore, containing the syphilitic virus, even when subjected to the most rigorous analysis, does not exhibit in its chemical, physical or microscopical characters, any differences from other pus, and may possess all the characteristics of what is termed healthy pus. (At one time it was claimed that a vegetable parasite had been discovered in the secretion.) Neither does the blood, subjected to the same rigorous test, present anything which may be termed diagnostic (unless Klebs' reported discoveries are true), although we know that if it is innoculated it will produce syphilis. It is claimed that the syphilitic virus may be preserved in a well corked vial, in a moderate temperature, for a number of weeks, without losing its poisonous character, or infecting properties. Cases are on record in which it has been thus preserved for a number of months without any loss of virility. Its poisonous quality can be destroyed by acids and other agents, or by altering its chemical constitution by excessive heat, and it is rendered inert by gangrene of the surface to which it is applied. Cold destroys the gonorrheal poison, but not the syphilitic virus, which may be frozen and again

thawed without losing its infecting properties. Could this be true if the disease was caused by a microbe?

All races, ages, temperaments and both sexes are equally liable to be affected by it. It is no respecter of persons; rich and poor are both alike subjected to its ravages if brought in contact with it. It is more severe in cold than in temperate climates, and always more severe in hot or cold climates in those who are not acclimated or are foreigners. When the affection first makes its appearance in a community, its progress is more rapid and the cases more severe in persons of enfeebled constitution or in those of a scrofulous diathesis. As regards race we should perhaps make one exception in modern times, and that is the Jews, who are rarely affected with syphilis. Out of a vast number of cases, we have seen but two who were afflicted. The reason of this comparative exemption is, we believe, due to the fact that the foreskin being gone, there is less chance for the retention of the virus upon the exposed parts; and furthermore the penis, especially the head and anterior portion of the skin, becomes hardened and toughened, thus rendering the circumcized ones less liable to an abrasion of the parts.

Syphilis produces its peculiar impression most readily when the virus is applied to a clean, ulcerated surface, an abrasion or a recent wound; but innoculation frequently takes place in other ways, it simply being necessary that the poison should be retained or kept in contact with a part until its structure is brought thoroughly under its influence. When the virus of chancre is applied to a sound external integument, which has become hardened by constant exposure to the air, it is generally innocuous. If, however, the syphilitic virus is applied to a perfectly healthy part not so hardened, several days usually elapse before it is absorbed or gives any evidence of its presence, because it has first to act as a common irritant corroding the surface, or it may be wiped off or otherwise destroyed before this occurs. It has been noticed that women, unconsciously, frequently give syphilis in this way without themselves being affected. For instance, they have sexual intercourse with a person affected with chancre, the pus of which may lodge in a fold of the mucous membrane of the vagina, and then, without washing, they repeat the act with another comer who takes up the deposited virus. Thus a woman is often merely a carrier of the disease. However, they are not the only ones who thus carry it, for there is a case on record in which a man having seen his mistress the early part of the night, and his wife the latter part, carried on the prepuce the syphilitic virus from the former to the latter. Ricord says: "Venereal diseases would be less frequent if women were more cleanly," and we may add to this that they would be still less frequent if men were less intemperate.

The syphilitic virus is communicated in a number of ways, not, as was believed in the fifteenth century, by the breath of the invalid, by

means of the air which surrounded him, by the perspiration, through the medium of holy water (which is not impossible), and in numerous other ways; but (1) by sexual intercourse, which is by far the most common; (2) by unnatural connection, giving rise to chancre of the anus and perineum; (3) by sucking the genital organs, as in circumcision, or as a crime, giving rise to chancres in the mouth, or upon the tongue or cheeks; (4) by vaccination (this is denied by many, but a sufficient number of cases are recorded to establish the truth of this method of communication); (5) by towels, spoons, forks, pipes, tumblers, children's toys, pens, pencils, bank-notes, cigars and other articles; (6) by chamber vessels and water-closets; (7) by surgical instruments, sponges and dressings; (8) by kissing (9) by nursing syphilitic children; (10) by the fingers of the affected individual. An affected individual may by means of the fingers innoculate his eyes, lips, nose or any abraded, raw or open surface upon any portion of his body. Physicians occasionally innoculate themselves in this way from their fingers, after examining women during labor, or those affected with chancre of the vulva, vagina or uterus. There must be an abraded surface, however. We recall to mind a case where a man was bitten on the nose in a street fight by a syphilitic person, and a chancre occurred at the site of the injury in about a week. Dentists sometimes contract the disease from examining patients with mucous patches in the mouth.

The length of time the syphilitic virus remains in contact with a part before it begins to act is still an open question, as in some cases a chancre is found within twenty-four hours, and, in other cases, not for a number of days or even weeks, one instance being reported by Fournier where the incubation lasted seventy-five days. The average time is from five to ten days. It is undoubtedly true that the virus acts immediately, but with greater or less rapidity according to the susceptibility of the patient; the greatest rapidity usually being observed in persons of a scrofulous diathesis.

PRIMARY SYPHILIS.

Primary syphilis is usually considered strictly a local disease, consisting of a chancre (something which eats) or ulcer of the genital organs, with or without a bubo, or swelling of the lymphatic ganglions of the groin, sometimes ending in suppuration and other bad effects; we, however, consider it a constitutional disease from the start, and look upon the chancre simply as the local manifestation of the disorder. If we take a small quantity of virus and insert it with a lancet just below the epidermis, at the end of the first day we shall see a little red speck, such as might follow any puncture of the skin. The part is slightly inflamed, hot, red and itchy. The following day a minute papule will be noticed, which changes into a vesicle about the fourth day, and is surrounded by an areola of a deep red hue. The next change is to that of a pustule on the fifth day, the pustule resembling that seen in small-pox, with the umbilicated appearance, and the distinctive areola. Now the structures about the pustule become hard from the deposit of plastic matter, and when pressed between the fingers feel like a mass of fibro-cartilage. On the sixth day, at the time the induration just described occurs, the sore becomes possessed of the requisite properties for supplying infecting matter. The pustule now turns dark, its contents solidify, and a small, round but thick scab forms, having the shape of a truncated cone. If we remove the scab, we shall find a circular and depressed ulcer, which looks as if it had been scooped out with a punch. The edges are steep and slightly ragged, the base firm and hard, and its bottom covered with a layer of grayish lymph. The discharge is thin, sanious or ichorous. This ulcer has received various names, viz., the infecting chancre, the indurated chancre, the Hunterian chancre.

The main points to be remembered are that the disease commences with a papule, becomes a vesicle, then a pustule followed by an excavated ulcer, with a hardened base, covered with pus which is capable of contaminating the fluids or solids of the body.

A chancre may appear upon any part of the body, although it generally occurs on the head of the penis, the frænum, the prepuce, the fourchette, the clitoris, the vulva, vagina or uterus, these parts being the ones most exposed to the contagion. Sometimes, but not very often, the urethra is attacked; and in other cases, chancres are met with at the mar-

gin of the meatus. It fact, any portion of the genital organs or other parts of the body may be the site of the sore, from the presence of an abrasion or scratch of a pin, although it most frequently appears on the corona or frænum, because the construction of these parts is such that the poison is more really retained until absorbed. In the female chancre is more frequent on the vulva, although the perineum is occasionally attacked. From the scratching of pins and buttons the abdomen is sometimes the seat of the disease.

Arthur Cooper remarks that the "primary sore on the face, fingers, etc., may be very unlike the characteristic hard chancre on the penis, and the accompanying bubo is not uncommonly attended with marked inflammatory symptoms, hence mistakes in diagnosis." We have seen quite a number of cases of chancre of the lip which were mistaken for other diseases.

There are no general or local symptoms that usher in the disease, with the exception of some heat, itching and increased sensibility of the part which has become innoculated. If the virus of a chancre is deposited on an abraded surface, it should be remembered that the primary sore commences as an ulcer, and does not necessarily pass through the stages described a moment ago, and the progress of the disease is more rapid than if otherwise absorbed. When the virus has been absorbed into the orifice of a mucuous follicle, the disease commences with a boil or abscess. A follicular chancre (i. e., one commencing in a follicle and appearing like an acne pustule) is more frequent in women than in men, and is usually observed on the labia majora as a small rounded ulceration, with a hair passing through it, and is depressed in the center with slightly elevated edges. The discharge is purulent and copious.

The patient does not usually present himself during the vesicular or pustular stage of incipient chancre, and the physician only sees him when the sore possesses all the characters of a well defined chancre, and thus we are unable to say how long it has existed. The early commencement of a chancre is so insidious, that it often passes unnoticed, and it is only when an ulcer exists that remedial measures are sought, or it may be so insignificant that the patient thinks it of no importance, and it is only by accident that it is seen, if at all. Surgeons have divided chancre into two varieties, the indurated or hard (also called the infecting chancre and the true chancre), and the non-indurated or soft (sometimes called chancroid or chancrelle), both dependent on the same poison, but modified or aggravated according to some unknown, or local or constitutional cause. There is always a period of incubation, but it is extremely variable in both—one day being the shortest time and seventy-two days the longest. The average time is from five to ten days. Why the syphilitic virus should produce an indurated chancre in one case and a soft in another is not known, but it is

supposed that this virus acts as other poisons, with very different effects on different constitutions. Bumstead states that a "soft chancre transmits either a chancroid or a syphilitic (hard) chancre, according to its origin. If it was derived from a chancroid, its innoculation will occasion a chancroid; if it was produced by the syphilitic virus, it will give rise to the initial lesion of syphilis." But we should have stated that Ricord, Bumstead and others maintain that there are two kinds of syphilitic poison, one giving rise to the true (hard) chancre, which is followed by secondary or tertiary symptoms, and the other giving rise to chancroids (soft chancre), a merely local trouble, often troublesome and persistent, but never followed by secondary or tertiary syphilis. If we accept the conclusion of Bumstead given above, we are always left in the dark as regards the prognosis, unless we can have brought before us the one from whom it was contracted, and perhaps five or six others before the last. The fact is, two persons affected from the same source do not necessarily have the same type of chancre, although they acquire the same poison, and as yet we have no rational solution of the problem. The whole subject of primary syphilis is at yet improperly understood, although the so-called dualists explain or attempt to explain the occurrence of hard and soft chancres contracted from the same identical sore, on the theory that some chancres are mixed sores capable of communicating both varieties. The soft, infecting chancre, it is also claimed, is only or rarely found in an individual not previously syphilitic. Our own views are that we have but one poison and that may cause a hard or a soft chancre. Hard chancre is sometimes contracted from the virus of a soft chancre, and vice versa, but this is exceptional, as chancres usually reproduce themselves in kind. Soft chancre is really a milder form of the disease. It is true that hard chancre is more often followed by constitutional symptoms, but there is plenty of proof that the soft chancre is also followed by the same symptoms in quite a number of cases. We only wish that we could believe that the soft chancre is not followed by constitutional effects, for it is much more frequent than hard chancre. The cases we have presented in the clinic of Hahnemann Hospital have shown conclusively that secondary syphilis is not rare after the soft variety of chancre.

Sometimes patients are not aware of the presence of chancre at all until some other complaint induces them to visit a physician, and he then makes the discovery for them. This is particularly true in the case of soft chancre when it commences as an ecthymatous pustule, the patient not supposing the difficulty to be anything more than a slight boil. Should it commence, however, as an ulcer, then his suspicions are immediately aroused.

The table below gives the differential diagnosis between hard and soft chancre.

HARD.	SOFT.
Shape, round, oval or a fissure; diameter of a 5 cent piece.	Occasionally round, but not usually.
Surface hollow, as if scooped out, and incrusted with a layer of dirty-grayish colored lymph, firmly adherent.	Superficial, flat, uneven, covered with a yellowish, grayish or dirty deposit. Often looks as if worm-eaten.
Edges are hard, adherent, elevated and inclined slopingly from within outward. Never undermined.	Overhanging, sloping or shelving, ragged, painful. When the sore is on the head of the penis, it looks as if cut out with a punch.
Adenitis constant, multiple and indolent.	Not constant.
Base hard like a mass of fibro-cartilage. Induration begins about the fifth day, and increases up to the tenth; the amount varies, being greatest on the head of the penis and less on the prepuce; is often absent in females; it lasts even after the chancre is cicatrized.	Not hard, except when due to inflammation or when irritating applications have been used, causing a plastic deposit.
Cicatrix, round, honey-combed.	No special characters.
Generally solitary, but not always by any means.	Multiple as a rule; often as many as six or eight, situated at the free margin of the prepuce. May all arise at once, or be formed from one by fresh innoculation.
Situated upon the genitals, lips, nipples or fingers.	Anywhere.
Does not spread.	Spreads; often phagedenic.
Pain absent.	Present, but moderate.
Areola distinct.	Has none.
Progress slow.	Rapid, but gets well slowly.
Discharge thin, serous, sanguinolent or ichorous—not very free, and difficult of innoculation.	Purulent and abundant, easily innoculated.
Bubo accompanies generally, or follows.	Not generally.
Secondary and tertiary symptoms are the result.	Also true, but not uniformly.
Period of incubation from seven to twenty days.	Two or more days.
Complications rare.	Frequent.

As regards the relative frequency of hard and soft chancre, it has been observed that in the lower classes the soft is much more common, probably four to one; while in the upper the indurated is seen in three cases out of four; thus proving, what was stated a short time ago, that intemperance, bad hygienic surroundings and bad food were remote causes for the soft variety of chancre.

How long does a chancre retain its specific character? We know that the contagious power is at its maximum during the stationary period of the ulcer, and that this power gradually diminishes as healing commences, but the exact time at which it ceases to be contagious we do not know. Some authors believe that a chancre loses its infecting properties in ten days, others in two weeks, and others not for many months, while many maintain that it loses the infecting virus as soon as healthy granulations are observed. At any rate, it is safe to say that it may possess contagious properties until it is completely cicatrized.

Ricord states that one attack of hard chancre protects the individual against a subsequent one, but as we have already stated proof is wanting on this point. In fact, enough cases have already been reported to show that it is not true. It is not denied that the same individual can repeatedly experience attacks of soft chancre. Other varieties of chancre are mentioned by authors, such as the inflammatory, phagedenic or ulcerative, sloughing or gangrenous, diphtheritic, etc., etc., but there is really no necessity of such a division, as these are complications, strictly speaking, of hard or soft chancre, dependent on want of cleanliness, frequent sexual intercourse, bad treatment, bad sanitary surroundings, alcoholic drinks, the state of the general health, the season of the year, too stimulating or too sparing diet, etc., etc.

The worst chancres we are called upon to treat are found in the lowest of the low, half-starved, drunken wretches, who have frequent intercourse with persons as vile as themselves. Do not imagine from this, however, that we never find bad cases among the rich, surrounded by every luxury, and enjoying the best of health; syphilis is no respecter of persons, and takes strange freaks at times.

All chancres are inflammatory affections, hence it is only when an excessive amount of inflammation is present that we are warranted in pronouncing it an inflammatory chancre. This variety occurs in dirty, intemperate or aged persons or in those who are obliged to follow very laborious occupations. Another frequent cause is the strangulation produced by phymosis, congenitial or accidental, and paraphymosis, which increase the flood of blood to the part. In this form of chancre there is considerable pain and swelling of the parts involved, accompanied by an increased discoloration, with more or less phlegmonous engorgement and an unhealthy aspect of the ulcer, which discharges a copious thin ichor. Erections are usually present, the prepuce œdematous, and the whole

penis greatly enlarged. The inflammatory chancre sometimes follows the too rapid administration of mercury or its compounds.

Sometimes gangrene sets in, usually in consequence of the confinement of pus under an elongated prepuce, and is always a serious complication. It always follows violent inflammation; and mental emotions, sexual indulgence, alcoholic drinks, want of cleanliness and intestinal disorders are predisposing causes. Gangrene affects usually the upper portion of the prepuce, the slough being limited to the tissues surrounding the ulcer and is always accompanied by phymosis. While affecting by preference the prepuce, it occasionally attacks the penis, or it may spread from one structure to the other, or may attack both simultaneously. The progress of gangrene is more or less rapid, and the destruction of tissue often very great—in bad cases destroying the whole penis. The occurrence of gangrene, which occurs early in the course of the chancre, is announced by a blackish spot, preceded and accompanied by an intense burning pain and increase of the other inflammatory phenomena. When the chancre is concealed, we recognize it by the swelling, pain and fetid sanious discharge which is always present. There is increased febrile action, with an accelerated and irritable pulse, considerable thirst, loss of appetite, constipation and restless sleep. Gangrene, as we have already stated, destroys the syphilitic poison.

Phagedena is a rare, but the most serious complication of chancre. It is very similar to hospital gangrene and occurs, but not invariably, in those whose constitutions have been ruined by mercury, intemperance, improper hygienic surroundings, improper and insufficient food and other debilitating influences. Sailors, prisoners, soldiers and inhabitants of tenement houses are the victims of this terrible affliction. The application of ointments (greasy) predisposes the patient to this form of chancre; so also does cold weather. Phagedena usually attacks the soft variety of chancre, but not invariably. When present, the sore extends rather slowly, but continuously, eating and destroying the parts, both laterally and inferiorly. Sometimes its ravages are very rapid, destroying in a few hours a vast amount of tissue. Its favorite sites are the gutter upon the head of the penis and the under surface of the penis at the side of the fraenum. If by chance the dorsal artery of the penis is in its way and becomes corroded, a serious, if not fatal, hemorrhage takes place. Occasionally phagedena occurs as an endemic in crowded hospitals, where the atmosphere is unhealthy and foul. Its duration is always prolonged and is difficult of arrest. It does not lessen the danger of constitutional infection, as gangrene does, provided that we accept the theory that primary syphilis is merely a local disease.

An interesting form of chancre is the serpiginous or erosive, the sore extending about, like a snake, in different directions, usually in circles or half circles and seemingly without limit. Another peculiarity is that

while one part of the ulcer is perhaps cicatrizing another portion is steadily advancing in an opposite direction. Sometimes the sore seems to be arrested and nearly well when rapid ulceration again sets in. We find this variety, as a rule, in scrofulous persons, such as are predisposed to phthisis, scurvy and chronic eruptions; such as have thin, delicate skins, which ulcerate from the slightest injury. This ulcer, though usually of a superficial character, sometimes penetrates deeply into the tissues, and, as it is essentially of a chronic nature, destroys a great amount of tissue before it can be checked. Its surface is uneven, covered with a dirty, grayish lymph, with more or less ichorous fluid, and its edges are thin, livid, ragged, steep and somewhat everted; often are so extensively undermined that they can be turned back like a flap. It sometimes extends under the skin of the penis as far as the abdomen, leaving as it heals an indelible white scar.

The French authors describe a diphtheritic chancre to be one which is very sensitive to the touch, accompanied by a sharp, continuous pain, and which is covered with a thick layer of glistening gray or yellowish white lymph, resembling leather. It is very rare, occurs only in persons of debilitated constitution, appears at any period of the ulceration and always denotes an irritable and inflamed condition of the parts. Nature is unable to convert this lymph into healthy granulations, and hence it is thrown off as of no further use. The edges of the ulcer bleed on the slightest touch, and sometimes very profusely, almost amounting to a hemorrhage. Any attempt to detach this diphtheritic layer is also attended by hemorrhage.

The diagnosis of chancre is in the majority of cases comparatively easy, when we consider the period of incubation and the condition of the base, and it is only occasionally that one is in doubt whether the ulcer on the genitals or elsewhere is or is not a chancre; but the physician may require considerable time to determine whether he has the hard or soft variety to deal with. The table given a few pages back will aid greatly if the sore is regular and uncomplicated. The physician should be very cautious about pronouncing a positive opinion concerning the ulcer upon the genitals, following a suspicious connection. Let him take time enough to fully observe its true character, and if necessary examine the person from whom it was derived. If all other means of diagnosis fail, a small portion of the suspected matter may be innoculated, which, if specific, will soon show itself. Chancre is liable to be confounded with simple abrasions, eczema, herpes, or balanitis. Herpes is an eruption of groups of vesicles, preceded by fever and slight digestive trouble. The vesicles are of a whitish color, about the size of a pin's head, and are seated on a red base and attended by considerable itching, heat and pain. They occur on the head of the penis and prepuce a day or two after exposure. When they occur on the lips the diagnosis is more difficult and more time is required.

Cleanliness and time will soon render a positive diagnosis possible. Innoculation will produce an ecthymatous pustule, if syphilitic. In eczema we find the vesicles still smaller, and greater irritation; the surface constantly discharges a thin, watery fluid, which stains and stiffens linen. The parts are swollen, red, hot and itchy. The prepuce is the site of the eruption. In balanitis the discharge is profuse, thick and muco-purulent, and the inflammation widely diffused. The history of the case often affords the means of diagnosis. Young or married men sometimes have abrasions accidentally produced by excessive friction during coitus, by the action of irritating secretions or the entanglement of a hair, and seek the physician for a diagnosis. In such cases time must be taken in order to determine whether the sore is of a specific nature or simple in its character. In all doubtful cases carefully examine the groins, for bubo is rare in non-specific affections.

As regards the prognosis, we may state, in general terms, that hard chancre is a mild disease, locally considered, its danger being due to its after effects, as shown in the secondary stage; but it should be remembered that secondary symptoms do not always follow, even when the chancre is left to itself. If the patient is experiencing a second attack of hard chancre the symptoms are very mild indeed unless phagedena is present. The duration of this sore is shorter than that of the other variety. The soft, on the other hand, is apt to be a serious affection, owing to the complications usually present (gangrene, phimosis, phagedena, etc.) and the extensive destruction of tissue. Secondary symptoms follow in a certain proportion of cases.

Having described chancre, it now remains to consider the treatment. The allopathic school usually employ nitrate of silver or some other caustic in the first instance, that is, if the chancre is seen before the fifth day. Some authors advise removing the diseased surface with the knife, while others doubt the propriety of such an operation and also affirm that it is attended with great danger of fresh innoculation from the diseased portions. Mercury and its compounds constitute the internal treatment. Berjeau very sensibly remarks "that the practice of destroying the chancre by lunar caustic is one of the most fatal practices of the present day. It does not by any means follow that because we have suppressed the outward manifestations of the disease we have thereby vanquished it. On the contrary, we have destroyed our most valuable guide, and one cannot possibly tell whether or when the patient is rid of his complaint. When we find the chancre yielding to the internal use of medicine, properly selected, we can be certain that the patient is in a fair way to recovery; but when caustics or various repellants are employed the disease becomes more intractable and complicated, secondary symptoms arise, or the patient is carried off by consumption or suffers for the remainder of his life from some chronic complaint, it being no uncommon thing to find

persons attributing, and with good reason, all the miseries of ill health they have undergone to syphilis badly treated in by-gone days. The proper remedy must be selected with reference to the form, extent and duration of the ulceration, the constitutional and moral disposition being taken into consideration."

"Cleanliness is akin to godliness," and the parts should be kept as clean as possible, either by the introduction of patent lint between the glans and the prepuce or by frequent injections of warm carbolized water under the prepuce. When the sore is extremely painful a sponge soaked in warm carbolized water can be squeezed over the ulcer from time to time. From an experience of many years we must decidedly protest against the use of cosmoline or other ointments. Ulcers thus treated rarely do well. The patient should be kept as quiet as possible, and if gangrene or phagedena occurs absolute rest should be insisted upon, as neglect of this precaution greatly prolongs and enhances the danger of the disease in spite of the treatment. Alcohol, stimulants of every kind, fat and salty food, should be prohibited. The best diet is rice, fish, corn starch, bread, fruit, and black tea or mineral water as a beverage.

Mercury, though a partial similium to chancre, is not a perfect one, hence we cannot always depend upon this remedy alone. It is indicated provided the patient has not already taken it in allopathic doses, when the ulcer has hard, sharp and irregular edges, painful to the touch, the base hard covered with lardaceous matter; in all recently acquired, superficial ulcers, with free secretion of thick pus; spreading and deeply penetrating ulcers on the glans and prepuce; phagedenic appearance of the chancre, with a thin, ichorous secretion; chancres which bleed readily are very painful, and secrete a yellowish, white fetid pus. The above symptoms are usually cured by mercurius solubilis. However it may be necessary to resort to

Mercurius cor or mercurius precipitatus rubrum, if the above fails to produce any effect in four or five days, especially when the ichor firmly adheres to the bottom of the ulcer and cannot be removed without considerable bleeding.

Cinnabar will be found of benefit in scrofulous patients when *Mercury*, although indicated, does not seem to benefit the patient. Old, neglected or badly treated cases.

Nitric acid would naturally be considered next, as it is the most valuable remedy in cases which have been mercurialized; and, in fact, it takes equal rank with *Mercurius* in the treatment of chancre. It is indicated in chancre with raised edges, easily bleeding and often profusely; superficial or elevated ulcer with zig-zag edges, when no signs of central granulation are present, or if they are, they are pale and flabby; ulcers with a thin, ichorous discharge, and a dark, dirty base.

Arsenic, when the chancre becomes gangrenous or phagedenic;

ulcers with a thin, offensive discharge, hard, readily bleeding edges, and proud flesh; gangrenous ulcers with bloody edges; painless ulcers with hard edges; ulcers secreting a copious watery, fetid ichor; persons who love warmth.

Thuya, for elevated ulcers with exuberant granulations; flat ulcers with unclean base and red edges; pale red vesicles about the ulcers. A very useful medicine in cases that resist *Nitric Acid*.

Aconite is sometimes temporarily useful for the inflammatory chancre, or when the exhibition of *Mercury* is followed by violent inflammation.

Argentum nitras for small ulcers, which spread slowly, and are covered with a lardaceous substance. *Silica* in scrofulous individuals, when the ulcer discharges an excessive amount of fetid, thin and bloody ichor. *Causticum*, when the discharge is acrid and corrosive; gouty, scorbutic or ill-nourished persons. *Sulphur* in psoric constitutions, when other remedies do not act, especially for *superficial* ulcers and excoriations, or for torpid ulcers; sores with the characteristic lardaceous secretion and discharge of fetid ichor.

Lachesis should be thought of in gangrene, and in ulcers surrounded by a bluish halo.

Iodine has cured quite a number of cases after the inguinal glands have become implicated. The urine has an ammoniacal odor. *Corralium* has served us in a few cases after the failure of mercury.

Other remedies might be mentioned, such as *Aurum*, *Hepar*, *Staph*, *etc.* The potency to be used is probably not as important as the right remedy. We use the higher potencies almost invariably, while others claim equal success with the lower. But we must caution you against using mercury below the third, as bad results are very apt to follow.

As has already been stated, hemorrhage sometimes arises during the progress of chancre, and it should be arrested at once. If the hemorrhage should occur from the destruction of some vessel, the compressing forceps or the ligature will be required, which, however, does not always arrest it; if from a number of points there is constant oozing, use compresses soaked in hamamelis; or, if still unarrested, some styptic, such as the persulphate of iron, should be employed. Nitric acid internally is very valuable. The treatment of erections, which are sometimes quite frequent, will receive special attention when we speak of gonorrhœa.

Chancre sometimes occurs in the urethra, and is then often mistaken for gonorrhœa on account of the similarity of the discharge. It is of the utmost importance to distinguish between these affections, and all cases should be very carefully examined. When the sore is just within the meatus, its most frequent site, there is but slight liability of being mistaken, for, on spreading the lips, it will be exposed to view; but when it occurs some two inches or more from the extremity of the penis (in

the membranous and prostatic regions), the diagnosis is often difficult. Chancres have been found by Ricord to extend along the whole of the urethra. The discharge is usually much less than in ordinary gonorrhœa; it is also thin or of a lighter color, mingled with streaks of blood. When the accompanying inflammation is unusually severe,it may be both profuse and of a thick, bloody character, or thick and yellow with a greenish tinge. The smarting, burning pain during micturition is referred to in a limited portion of the canal, and is not so great as in gonorrhœa, while the site of the urethral chancre is nearly always indicated by a kernel of induration, easily distinguished by the thumb and finger. Erections are not as frequent nor as painful as in gonorrhœa. Chancre in the urethra, as elsewhere, may be followed by secondary symptoms. Bubo is a rare complication, but contraction of the urethra is nearly always one of its effects. The only positive diagnostic characters of chancre in this situation are furnished by inoculation. The induration may exist in gonorrhœa in consequence of the development of an abscess, and from other causes; the discharge, if profuse and thick, is not diagnostic; the scalding during micturition may be slight also in gonorrhœa, and the extraordinary length of time between the indiscretion and the onset of the disease may also be present in gonorrhœa. It should have been stated before that the period of latency of chancre in the urethra is much longer than when in other situations, on the theory that the quantity of virus is small, or that the virus becomes entangled in one or more of the lacunæ of the tube, and is incapable of exciting the same influence as when brought in contact with an abraded surface. If urine is passed soon after the virus is introduced into the urethra, it is either washed away or neutralized by this fluid.

The treatment of chancre in the urethra will vary according to circumstances. If the sore can be seen by separating the lips of the meatus or by the ear speculum, the treatment just given for chancre in other situations will be applicable; if not, we must depend entirely on the symptoms given by the patient, and then the treatment does not differ materially from that of gonorrhœa. The remedies will be mentioned when we speak of the latter affection.

Chancre in the female necessarily requires the same treatment as in the male. The seat of the sore is more often the vulva than elsewhere, although, as we have already remarked, the vagina and uterus are sometimes affected. The chancres are sometimes concealed, or partially so, between the rugæ of the skin on the external genitals as well as in the vagina, especially when the sores are small. Females are more often affected with the soft variety of chancre than the indurated, and the pain is much greater than in the male. Frequent washing of the parts is absolutely necessary, as is rest, also, if there is much inflammation.

Chancre appears, as has been before stated, on the fingers, lips, tongue, eyes, nose, cheek, scalp (rarely), anus, trunk, extremities, etc.,

wherever the virus has been accidentally or purposely inoculated, and the diagnosis is deduced from the history of the case, and a very careful observation of the suspected ulcer. No matter what the situation, the treatment is the same, viz., frequent cleansing of the part, and the administration of that remedy which covers the most symptoms of the case.

Phimosis is that condition of the penis in which the prepuce cannot be drawn back of the corona glandis, and does not require any special attention. It is a very inconvenient complication as it prevents our ascertaining the exact condition of the ulcer, and may cause gangrene. It is caused, when not congenital, by the infiltration of fluid into the cellular tissue of the prepuce, forming a bulbous swelling at the extremity of the penis, its borders being usually inflamed, enlarged, cracked, and often so narrow that but a small portion of the secreted pus can make its escape, thus rendering the retraction of the prepuce behind the glans impossible, and the retained pus collecting underneath forms a fluctuating swelling. Blenorrhœa is almost always present, and persons with a long, narrow prepuce are most subject to phimosis. The remedy administered for the chancre is usually sufficient for the cure of this complication, but in some cases *Rhus tox*, is required, when there is a puffy swelling of both prepuce and glans, with itching and moist eruption on the scrotum.

Apis may be of service if the swelling is of a dropsical character, the parts being tense, shining and transparent.

Sulphur is valuable in scrofulous patients when other remedies have failed.

Cinnabar is indicated when there is a dark red, hot and inflamed prepuce.

If gangrene threatens, the knife should be used dividing the parts carefully, and immediately washing the edges with a solution of carbolic acid. Above all, do not forget to insist on cleanliness. Order the patient to inject under the foreskin a little carbolized water several times a day.

Paraphimosis, that is retraction of the prepuce behind the glans so that it cannot again be brought forward, is occasionally present, and is a much more dangerous complication than phimosis, for, if the constriction is not immediately relieved, it may cut off the circulation of blood in the glans, and eventually lead to swelling, inflammation and gangrene of the part, a frequent result. An effort should be made at once to restore the parts by manual efforts aided by chloroform. Before attempting reduction, the penis should be soaked in cold water, and the swollen part kneaded between the fingers. If this fails, as it not unfrequently does, there is no remedy but the bistoury; a narrow-bladed one is the best to slip beneath the constricting ring formed by the prepuce, and it should be carried back toward the pubes, and then turned

cutting outward. In milder cases, the same remedies that are recommended for phymosis may be used.

Bubo, strictly speaking, is an enlargement of one or more of the lymphatic ganglions of the groin, although the term with propriety may be and has been applied to any engorgement of the lymphatic ganglia. Anything tending to irritate or inflame the lymphatic vessels leading to these glands may produce it. The most frequent causes being excessive sexual indulgence, strains, gonorrhœa, catarrhal or cutaneous inflammation, fatigue from protracted exercise, forced marches, injuries of the lower extremities, tight boots, or the presence of a boil on the thighs, nates or perineum. It occasionally occurs without known exciting cause. The inflammation attacks the glands nearest and in direct communication with the ulcer, and almost invariably the ganglia of the superficial chain.

Bubo is very liable to occur in young people of a scrofulous diathesis, often arising from the most trivial causes and disappearing usually without much treatment. Bubo, however, arising from syphilitic cause is a specific disease, the result of inoculation with the virus of chancre, and eventually furnishes a secretion similar to that by which it was itself produced. An open or suppurating syphilitic bubo is really a chancre, and is merely a primary form of disease. The syphilitic bubo arises two or three weeks after the first appearance of the primary sore; in a few instances coming on as early as the eighth day, and in others the time is postponed for even four or five weeks.

Bubo follows both varieties of chancre. Gross says: "An active open state of the ulcer, and the smallest conceivable amount of inflammation in the structures immediately around, are, other things being equal, the conditions most favorable to the development of the true syphilitic bubo."

The hard chancre is always followed by bubo, while the soft is thus followed only once in three times. The swelling after hard chancre involves several ganglions, and is hard and chronic, with very slight disposition to suppurate (if pus does form it is not considered specific), although all authorities contend that it is sure to contaminate the system. On the other hand, the bubo following soft chancre usually affects but one gland, runs its course rapidly, terminating in an abscess, the discharge being abundant and of a specific character. The bubo generally forms on the side on which the chancre is situated, and exceptionally and rarely on the opposite side. A very bad form of bubo occasionally occurs at the root of the penis, or upon the pubes, caused by the presence of an infected ganglion.

Males suffer much more frequently from bubo than females, owing to the difference in the arrangement of the lymphatic vessels—those in the male passing directly from the seat of the disease, while the course is more circuitous in the woman. In chancre of the uterus and upper

part of the vagina, bubo is uncommon, and the same is true in chancre of the urethra in men. The older writers on syphilis asserted that a syphilitic bubo occasionally occurred without the intervention or antecedence of chancre, and this was called a primary bubo. This theory was incorrect, the proof insufficient, and fortunately has but few partisans at the present day. It may happen that the chancre is quite small, and thus escape the attention of both patient and physician, for there is no reason to doubt that very small and insignificant ulcers sometimes appear on the genitals and are followed by violent constitutional symptoms.

A bubo is a very uncertain kind of swelling; it may remain stationary for a number of weeks or months, or it may become hardened, the latter being considered a dangerous form by those who do not think chancre a constitutional affection, as they claim that one can hardly escape contamination of the system when this occurs. Gross calls the bubo a hot-bed, not merely for the temporary lodgment of the virus, but for its zymotic operation and its gradual extension to other and more important structures. When a bubo suppurates, it is important that the matter should be evacuated early, otherwise the pus is apt to burrow among the neighboring tissues, causing an extensive sinus. Many writers assert that a suppurating bubo can be cured without an incision by aspirating the swelling and then injecting vaseline and iodoform. The discharge from an open bubo varies greatly, sometimes being thin and ichorous; at others, thick, yellow and bloody, although there is seldom hemorrhage. The edge of the sore exhibits about the same appearance as that of an ordinary chancre, and the bottom is covered with a dirty, greenish or yellowish matter. This open bubo may become phagedenic the same as a chancre, and then produces just as frightful a destruction of tissue. Again, it may become gangrenous—true gangrene, which latter complication only occurs in half-famished, dirty persons, who have no regard for cleanliness, the inmates of prisons, almhouses, cellars and other foul habitations. The patients usually die under the regular practice.

There is a form of bubo called the creeping, which is the exact counterpart of the serpiginous chancre, creeping snake-like about in different directions. Syphilitic bubo is liable to be confounded with bubo from other causes, but the following points render the diagnosis comparatively easy, viz.: the history of the case; the syphilitic bubo comes on about two or more weeks after the chancre; the common in one or two days after the exciting cause; the syphilitic bubo lasts several weeks or months, the common disappears with the exciting cause; the first suppurates and ulcerates, the latter hardly ever, except in scrofulous persons; the pus from one is inoculable, from the other, never; the syphilitic bubo is situated above Poupart's ligament, affecting generally but one gland—the common below, or under the ligament affecting several glands usually.

SECONDARY SYPHILIS.

This brings us to secondary syphilis, another step in the progress of the disease. This stage follows the primary sore in from four to twenty weeks, the average time being six weeks, and is transmissible by hereditary descent, In general terms, the tissues now affected are the skin and the mucous membranes, not necessarily both at the same time, but sometimes the skin, at others the mucous membranes, and again both. The exact time of the appearance of secondary symptoms cannot be foretold, as much depends upon the mode of life of the patient and his personal idiosyncrasies. Occasionally we find rheumatic pains present during this stage, but these do not by any means denote affection of the bones. What the poison is and where it resides are questions which are still undecided, and which we have already discussed. We know, however, that it circulates in the blood. These symptoms follow both varieties of chancre. It is not uncommon for these symptoms to present themselves before the chancre or bubo has disappeared, but usually if the patient is under proper treatment the primary sore has entirely disappeared, and the sufferer imagines himself well before they make their appearance.

The following facts should be carefully noted: 1, That the hard chancre is nearly always followed by secondary symptoms; 2, That the soft chancre is also followed by secondary symptoms, if multiple or of great extent; 3, That secondary symptoms are contagious and inoculable; 4, Chancres which become gangrenous are not apt to affect the system; 5, Feeble and scrofulous persons are more liable to secondary than healthy persons; 6, Mercury is a predisposing cause of secondary syphilis; 7, Chancre of the urethra is rarely followed by constitutional contamination; 8, If the local inflammation is unusually severe, secondary symptoms rarely occur. The foregoing points should be remembered, for on them you base your prognosis. Secondary syphilis is both contagious and inoculable, and produces a degree of contamination which is almost impossible to cure without prolonged and skillful treatment. If we take upon a lancet a small portion of the serum of the blood of an infected person and insert it into the arm of a healthy person, a chancre will be the result. This same serum, however, will have no effect upon the arm of the person from whom it was taken, or upon any other

syphilitic individual. The period of incubation after inoculation is from twenty to forty days. We have already referred to the propagation of syphilis by means of vaccination, the lymph used having been contaminated with the blood of the infected individual. In this connection it may not be amiss to say that writers upon this subject formerly believed that syphilis once implanted in the system never could be eradicated, and that it ran through one generation after another; but these views are not held at the present day, and syphilis is considered a curable disease. Our own experience teaches us that many of these patients are thoroughly cured and afterward give birth to healthy children, entirely free from all traces of this dreaded malady.

The symptoms first noticed in the invasion of secondary syphilis are very variable. The following are often noticed, not all of them by any means in any given case, but one or more of them, and of varying intensity. For a number of days, previous to the eruption, the patient complains of malaise; he is not really sick, and yet he is not well; has some dizziness at times; headache on one side only at night; he is gloomy and low-spirited, with aversion to doing anything; has the blues in fact; his appetite is impared; his breath is short, with a quickened pulse, and his heart palpitates from time to time; his limbs and joints feel sore and stiff, especially at night; he has a pain under the sternum, with some tenderness to the touch; his look is dull and heavy; there is more or less gastric trouble, with constipated bowels; the urine is scanty, and high colored; with acid reaction; he is easily fatigued; his limbs are numb; his sleep is restless, and full of anxious dreams. The post cervical glands will be found indolently indurated at this time, and the hair will commence thinning out, as the result of feebleness.

A few days after, he has what is termed the syphilitic fever: that is, he is suddenly seized with chilly sensations or rigors, followed by moderate fever (occasionally very high fever), or by fever and profuse morning sweats, reminding one very forcibly of the sweats of pulmonary tuberculosis. The type of the fever bears a great resemblance, at times, to intermittent or remittent fever, and at others to rheumatic fever. This fever is present in only twenty-five per cent. of the cases. The eruption now makes its appearance, and the fever soon disappears, and with it the other general symptoms mentioned a moment ago. In place of the eruption upon the skin, we may have an affection of the mucous surface.

The skin eruptions are of an erythematous, scaly, papular, tubercular, vesicular or pustular character, differing in intensity in different individuals. No two cases are exactly alike, although all present a striking family likeness. Some of these eruptions belong to both the secondary and tertiary stage, because we cannot, as yet, exactly define the limits of each definitely. In fact we cannot say that any one variety belongs exclusively to either secondary or tertiary syphilis. It is almost

impossible to give any general characteristics that shall apply equally to all syphilitic eruptions. We are only able to give some general rules which have some exceptions. They often present varied lesions side by side; macules, papules, pustules may be associated together. They pursue a chronic course, and occur upon all parts of the body, but more especially upon the inside of the arm and thigh, face, forehead, nose, back and shoulders. They are not always of a copper color in their earlier and more acute stages, but invariably present this appearance after a time. They are readily distinguished from non-specific skin diseases by the history of the case; by the absence of heat, itching and pain; by the peculiar copper color; by the tendency to destroy the tissues on which they are seated, and by the concurrence of lesions of the integument and mucous membranes.

The erythematous form, the earliest and the most common, sometimes comes on before the disappearance of the primary symptoms, usually in about two months. It may appear suddenly or gradually, with or without pyrexial disturbance, the spots appearing on the skin and mucous membrane, at first of a red color, then coppery. They are of circular shape, one-eight to one-half inch in diameter. and do not project above the level of the skin. They are most prominent and numerous on the thorax and belly, although they may appear upon any part of the body; they do not entirely disappear under pressure; are rarely, if ever, confluent, healthy skin existing between them, and usually pass off with a very slight desquamation of the skin. Oftentimes the spots are considerably smaller, more irregular in shape, and of a brighter red color. This variety, the mildest of all syphilitic eruptions, has received the name of roseola, from its great resemblance to measles. The physician frequently is the first to discover it, as there is no itching, heat or pain. It is found all over the body, except the sides of the neck. There is no perceptible elevation of the skin in either variety. After ten days, more or less, the eruption fades and becomes dingy or grayish brown. Its duration varies from a few days to four or five weeks, and it may relapse. The history of the case, the absence of itching, its location, and other difference just mentioned, distinguish it from other skin diseases for which it might be mistaken. It lacks the catarrhal symptoms of measles, and hence could not be confounded with rubeola.

The scaly variety of syphilis makes its appearance from six to ten months after the primary disease, and usually without any marked precursory symptoms. It may form the connecting link between secondary and tertiary syphilis, or may belong wholly to one or the other stage. It is quite generally associated with other well-marked symptoms, such as inflammation of the throat and palate, iritis, and bone pains of greater or less intensity. The eruption generally occurs in small patches of an irregular or circular shape of a red and somewhat

coppery color, and is most common on the forehead, scalp, face, arms and palms of hands and soles of feet, although it may appear upon any part of the body. The scales are distinct, hard but small, of a dull, opaque-grayish or whitish appearance, or they may be thin and filmy, resting on a copper-colored base. Often they are circular in form and slightly depressed in the center, the skin underneath showing a tendency to ulcerate or to form cracks and fissures. If ulceration does take place a thick, brown, dry crust soon forms. When the ulcer has healed, a whitish cicatrix, somewhat depressed in the center, remains to mark the original site of the sore. The most frequent form of this variety is psoriasis palmaris and plantaris. This affection commences with the appearance of from three to a dozen or more small, flat papules, devoid of itching or pain, which increase in size, forming irregular patches by fusion, after a time. The papules are prone to seek the furrows in the hand, and it is here we most frequently see the disease as a true scaling syphilide. The diagnosis is sometimes quite difficult. The history of the case should be carefully considered, and the co-existence of other lesions sought for. Ordinary psoriasis is not usually confined to the hands and feet but occurs elsewhere at the same time.

The vesicular variety of syphilis is of very rare occurrence, is always chronic and greatly resembles eczema and herpes in its general characacters. Its favorite site is the neck, chest and extremities, the face usually escaping. In very rare cases, the vesicles are so numerous as to cover nearly the whole surface of the body. When present it marks the transition of primary into secondary syphilis, coming on as it does about eight weeks after the appearance of the chancre. The eruption appears first as minute circumscribed pimples, soon changing to vesicles filled with a transparent serous fluid; and surrounded by the characteristic copper-colored areola. The contents may become turbid and purulent, but are finally absorbed or dry down into thin scales, which, when they fall off or are removed, leave the part a dirty yellow hue. As accompanying symptoms usually present, we may mention rheumatic pains in the bones and joints, and dryness of the throat. The diagnosis is frequently difficult without the previous history of the case, for there is nothing aside from the copper-colored areola to distinguish it from other vesicular diseases, except the absence of itching.

Syphilitic bullæ are simply enlarged vesicles, and appear as pemphigus and rupia. Pemphigus is subacute and transcient in its character, is rather rare and appears early in secondary syphilis, but never except in children, as the first eruption. In children of syphilitic parents it is not uncommon, and nearly all the little ones die. *Hepar sulph.* served us well in one case. The vesicles usually run an indolent course after their contents become pustular, do not increase much in size, and finally crust over. These crusts, on falling off, leave pigmented spots.

Rupia is more common, appearing sometimes during the first year, but usually very late in the disease. It is essentially a disease of adults, and pursues a very chronic course. All the lesions of rupia begin as a red spot, which soon is the seat of a large or small bulla, the contents of which soon become purulent, and then dries into a yellow or greenish brown crust of variable size, but usually one-eighth to one-fourth of an inch in diameter. Underneath this crust is an ulcerated, infiltrated surface, which extends somewhat beyond the original crust. As they grow older and new additions are added from the bottom, gradually elevating the mass, the crusts become darker and the base presents the usual copper-colored areola. The lower crust may grow to the size of three or more inches in diameter. The scabs constantly cover foul ulcers, for if at any time we remove the oyster shell as it is called, we find a foul, grayish looking ulceration, which again becomes crusted over, and thus it continues until influenced by anti-syphilitic remedies. Rupia may occur anywhere on the body, but usually selects the forearms or lower extremities. In the worse case which came under our observation, the forehead was the seat of the disease, which is rather an infrequent place of development. There is no pain at any time. The diagnosis is easy, as there is but one other disease which at all resembles it, and that is psoriasis rupioides; but in the latter affection there is a want of the characteristic dirty color of the scabs and the copper-colored areola. The prognosis should be guarded, as this is an affection of considerable gravity and really belongs to the tertiary stage.

Syphilitic pustules are less common than erythematous and papular eruptions, but present similar appearances outwardly to other pustules, except that each pustule rests upon a hard copper-colored base. They are found upon any part of the body, scalp, face or extremities; they may be single, multiple or confluent; their shape is round or oval; the size varies from that of a pin's head to that of a hazel nut. They occasionally exist as the earliest eruption at six weeks, or with the primary disease; but no matter when they appear, they always denote a severe constitutional contamination. The number of these pustules varies greatly, sometimes being so numerous that hundreds are scattered over a small surface, and the suffering and exhaustion may be so great as to destroy life. They may begin as papules or as distinct pustules, and relapses are very common. There are two varieties, the one termed psydracious in which the pustules occur in groups, and the other phlyzacious in which they are scattered. After two or more weeks, the contents of the pustules escape, concrete and form scabs of a varying thickness, of a yellow or greenish black color, and quite firmly adherent. In simple cases under small crusts, there is usually little if any ulceration, but a chronic induration, a dusky stain or a small cicatrix. In severe cases under large crusts, deep, circular ulcers are exposed with a foul,

grayish bottom, or a covering of thick, yellow pus. The edges are circumscribed, perpendicular, and often undermined; in healing, a white indelible scar remains. These ulcerations are long-lasting and very difficult to heal. This form of syphilis is often a connecting link between the secondary and tertiary stage; is sometimes associated with iritis, and with the tubercular and papular eruptions, and less frequently with roseola and the squamous forms of syphilis. If high fever accompanies, it may be mistaken for small-pox, but a day or two clears up the diagnosis.

We have a form of syphilitic acne which appears in the secondary stage (third to sixth month), accompanied by fever. The pustules are scattered over the whole body, thus differing from ordinary acne, which is confined mainly to the face and shoulders. The general health is more frequently impaired after this rash than after others. After the disappearance of the pustules, small brown spots remain for some time, and exceptionally, minute cicatrices.

Syphilitic ecthyma appears during the first year, and is distinguished from non-specific disease by the history of the case, the absence of itching, and light inflammatory action. A guarded prognosis should be given in these cases.

The tubercular form of syphilis, the most formidable and most frequent of all, is really an exaggerated form of syphilitic papules. It makes its appearance at any time, from one to twenty years after the primary sore, in cases that have not been properly treated. The tubercles begin as small, red, copper-colored eminences, which slowly increase in size, until when fully developed, they are as large as an olive or an orange. They may occur upon any part of the body or face, and possess a decided tendency to ulcerate. They are of a rounded, flattened or conoidal shape, isolated in groups or arranged in perfect circles or segments of circles. They are smooth, and have a shining appearance; cause little or no pain, heat or itching, and become covered in a short time with a dry, scaly incrustation, very similar to psoriasis, which is generally reproduced as fast as it falls off. In the aggravated form, the tubercles are very large, from ½ to 1 inch or more in diameter, at first of a dark red, or a light pink color, becoming a deep, violet hue, and surrounded by a well-marked copper-colored areola. The course of the eruption is very slow, but in a few months or years a number of tubercles inflame and suppurate, giving rise to deep, foul, painful ulcers, with sharp-cut edges, resting upon a hard base. Such cases, fortunately, are very rare. The thick, greenish-black crust, which covers the ulcer, is frequently renewed, showing, when removed, that the sore is constantly spreading. In broken-down subjects, or drunkards, the ulcers may merge together, forming sores of frightful size, which in healing, leave disfiguring scars, somewhat depressed. It should be remembered that syphilitic tubercle

is a very serious form of disease, as it may last a long time, exhausting the patient, and the eruption may be kept up by successive outbreaks. Relapses occur even when we have every reason to expect continued improvement from skillful treatment.

There are two varieties of papular syphilis, which may appear as the first eruption on the skin, or may be associated with roseola. The first consists of very small, hard, solid elevations, about the size of a pin's head or larger, conical or rounded, disjointed or grouped, devoid of fluid, and terminating in desquamation. They may appear upon any portion of the body, but seem to prefer the anterior part of the trunk. The papules are sometimes umbilicated; are of a pale rose color at first, and afterward of a coppery red, and are surrounded by violet areolæ, which are often confluent. The color disappears under pressure at first, but not at a later stage. They appear simultaneously upon different parts of the body, backs of the hands, scrotum, penis, and often the face (similar to acne), disappear in a short time, and are followed by desquamation of the skin, rarely resulting in ulceration. Upon the scrotum and penis, however, they usually become excoriated, and are then transformed into condylomata. Frequently, these papules are seated at the openings of follicles, a feature rarely noticed in any other form of syphilitic papule. After their disappearance, pigmented spots remain, which become white only after a number of weeks. In the other variety, the eruption is developed gradually, commencing with minute, yellow spots, which rapidly increase in size, and are located on the forehead, scalp and upper and lower extremities. The papules are larger than the other variety, with a diameter of from ¼ to ½ inch or even more. They are flat, round or oval, grouped, of a light, red color, soon becoming coppery, and devoid of an areola. The surface of the papule becomes covered with a thin, dry, grayish pellicle, which is re-formed as fast as it is thrown off, until the disease is finally arrested. The skin between the papules becomes dry and shriveled, of a dingy, yellowish color, and is apt to be the seat of a constant exfoliation of the skin. No scars are left upon its disappearance, simply pigmented spots. Upon surfaces that are moist, as the perinæum, for example, the papules become transformed into condylomata. This result is usually met with during the second or third year of syphilis, and very rarely during the first twelve months. The earlier its appearance, the more copious is the eruption; the later it comes on, the more apt it is to be accompanied by iritis, alopecia, condylomata, and pustular eruptions on the hairy parts.

Treatment. Our old school friends recommend mercury, tartar emetic, iodide of potash, etc., etc., for the different variety of skin affections, combining them with aconite for violent fever, with morphine for restlessness, sleeplessness, etc., with sulphate of magnesia for constipa-

tion, etc., etc. It will be difficult to give you the Homœopathic treatment for these eruptions without other symptoms, so we shall content ourselves with a brief resume of the more important only, recommending that in every case you should note carefully all the symptoms and select a remedy in accordance with them:

For syphilitic erythema and roseola—*Aurum, Ant. crud., Ant. tart., Ars., Bell., Calc., Canth., Lyc., Merc., Nit. ac., Phos., Sulph., Sulph-ac., Tereb.*

For squamous or scaly diseases—*Alum, Alum carb., Ars., Ars. jod., Aur., Bry., Calc., Carbol. ac., Clem., Coral., Dulc., Hep., Iris., Kali. brom., Led., Lyc., Merc., Nitr. ac., Petrol, Phos., Phos-ac., Phytol., Psor., Rhus., Sep., Sulph., Tell., Teucr.*

For vesicular—*Amm. c., Ant. c., Ant. t., Arg., Ars., Aur., Brom., Bry., Calc., Canth., Carbo. veg., Carbol. ac., Clem., Dulc., Graph., Hep., Iris., Kali., Lach., Led., Lyc., Merc., Mezer., Natr. m., Nitr. ac., Petr., Phos., Rhus., Sep., Sil., Staph., Sulph., Thuj.*

For pustular—*Alum, Alnus, Amm. c., Ant. c., Ant. t., Ars., Ars. jod., Baryta., Calc., Carbo. veg., Carbol. ac., Caust., Con., Dulc., Graph., Hep., Kali., Kreos., Lach., Lyc., Merc., Natr. m., Nitr. ac., Phos., Phos. ac., Rhus., Sarsap., Sep., Sil., Staph., Sulph., Viola.*

For papular—*Ars., Bry., Calc., Caust., Cicuta., Con,, Dulc., Graph., Lyc., Merc., Mur. ac., Nitr. ac., Phytol., Puls., Rhus., Sil., Staph., Sulph., Thuj.*

For tubercular—Same remedies as papular.

Alopecia, or falling out of the hair, is more a symptom than a disease, and may arise during the course of many other acute or chronic diseases. When due to syphilis, which is of very common occurrence, it generally commences within eight or ten weeks, dating from the commencement of the primary sore, and is attended by no marked subjective symptoms as heat or itching. It arises gradually, the hair coming out when combed or pulled, in patches or circular disks of variable size. Upon examining the head well-marked copper colored spots will be found as a rule. It varies greatly in degree, being generally quite moderate, but in some cases not only the hair of the head, but that of the face, pubes, genitals and other portions of the body, falls out. The hair first becomes usually dry, loosing its soft and glossy feel, and is stiff and brittle, soon afterward falling out in great abundance, leaving exposed to view circular blotches of a dusky, copper color. Accompanying this affection we usually find wandering rheumatic pains in the muscles, bones and joints. Even in very severe cases, in persons of middle age, we may expect the hair to grow again, but it is never so soft and glossy as before, but becomes coarse, stiff and sparse. Ulcerating eruptions which affect the scalp sometimes destroy the follicles, and in such cases we expect as a matter of course permanent bald spots as the result.

Alopecia is due to the impaired nutrition of the hair follicles, occasioned by the adynamic influence of syphilis.

The following remedies are valuable for falling out of the hair: *Alum*, *Ambr.*, *Amm.*, *Amm. m.*, *Ant. c.*, *Ars.*, *Aur.*, *Bar.*, *Bell.*, *Bor.*, *Calc.*, *Canth.*, *Carbo. an.*, *Carbo. veg.*, *Caust.*, *Chel.*, *Colch.*, *Con.*, *Creos.*, *Cycl.*, *Dulc.*, *Ferr.*, *Graph.*, *Hell.*, *Hep.*, *Ign.*, *Iod.*, *Kali.*, *Lach.*, *Lyc.*, *Mezer.*, *Magn.*, *Merc.*, *Natr.*, *Natr. m.*, *Nitr. ac.*, *Op.*, *Par.*, *Petr.*, *Phos.*, *Phos. ac.*, *Plumb.*, *Rhus*, *Sarsap.*, *Sabin.*, *Sec. corn.*, *Selen.*, *Sep.*, *Sil.*, *Staph.*, *Sulph.*, *Sulph. ac.*, *Zinc.*

Falling out in tufts, *Phos.*

Falling out in circular patches, *Ars.*

Falling out from back of head, *Calc.*, *Carbo. veg.*, *Hep.*, *Petr.*, *Sep.*, *Sil.*, *Staph.*, *Sulph.*

Falling out from crown of head, *Bar.*, *Calc.*, *Carb. av.*, *Phos.*, *Hep.*, *Lyc.*, *Nitr. ac.*, *Plumb.*, *Selen.*, *Sep.*, *Sil.*, *Zinc.*

Falling out from forepart, *Ars.*, *Bell.*, *Hep.*, *Merc.*, *Natr. m.*, *Phos.*, *Sil.*

Falling out from sides of head, *Bov.*, *Graph.*, *Kali.*, *Phos. ac.*, *Staph.*, *Zinc.*

Falling out from temples, *Calc.*, *Kali.*, *Lyc.*, *Merc.*, *Natr. m.*, *Par.*, *Sabin.*

Falling out from eyebrows, *Agar*, *Bell.*, *Caust.*, *Hell.*, *Kali.*, *Mezer.*, *Par.*, *Plumb.*, *Selen.*

Falling out from whiskers, *Agar.*, *Ambr.*, *Calc.*, *Graph.*, *Natr.*, *Natr. m.*, *Nitr. ac.*, *Plumb.*, *Sil.*

Falling out from moustaches, *Bar.*, *Kali.*, *Plumb.*

Falling out from nostrils, *Calc.*, *Caust.*, *Graph.*, *Sil.*

Falling out from genitals, *Bell.*, *Hell.*, *Natr.*, *Natr. m.*, *Nitr. ac.*, *Rhus*, *Selen.*, *Zinc.*

Falling out from body generally, *Ars.*, *Calc.*, *Carbo. v.*, *Graph.*, *Hell.*, *Kali.*, *Natr. m.*, *Op.*, *Phos.*, *Sabin.*, *Sec. corn.*, *Sulph.*

Hair brittle, *Ars.*, *Bell.*

Hair dry, *Aloe*, *Alum.*, *Bad.*, *Chel.*, *Hip.*, *Kali.*, *Phos.*, *Sec. corn.*

Hair stiff, *Ars.*, *Canth.*

We have already spoken briefly of cervical adenitis. Suffice it to say say that usually the posterior cervical glands become affected at a very early period of secondary syphilis, becoming enlarged to the size of an almond, and slightly tender at first, though never painfully so. It will be remembered that in health these glands are so small that they can scarcely be detected. This engorgement of glands at a distance from the primary sore and at about the sixth or seventh week, is considered the earliest and most characteristic symptom of secondary syphilis. It is present in over ninety per cent of all cases. There are seldom more than one or two glands involved, although in very rare cases there may be as many as six or eight.

The posterior cervical glands referred to are situated along the upper half of the posterior border of the sterno-cleido-mastoideus muscle. The glands never suppurate, at least there is only one case on record showing an exception to the rule. The duration of these glandular indurations is quite protracted. This enlargement of glands is only important from its constancy as a means of diagnosis, and is something the physician should never fail to look for in cases of difficult diagnosis. They require no special treatment, as the remedies adapted to the other symptoms present remove this affection also. The remedies exerting a special curative action on these glands are *Bar.*, *Calc.*, *Hell.*, *Iod.*, *Mur. ac.*, *Petr.*, *Phos.*, *Sil.*, *Sulph.*

We shall next consider the various affections of the mucous membranes, bearing in mind that while the cutaneous and mucous surfaces are but one continuous membrane, the constant moisture, exposure to friction, etc., of the latter, very greatly alters the character of the various eruptions. These affections, as we have already stated, may exist with the eruption upon the skin or independently of it; but, as a rule, both structures are affected at the same time. They make their appearance usually after the chancre has disappeared, but in many cases even before this has occurred. The parts most frequently attacked are the tonsils, palate, pharynx, tongue, cheek and lips, although any portion of the mucous membrane which is visible may be affected. As regards the stomach and bowels, all we can say is that nothing satisfactory is known, although the anus and rectum are frequently involved. It is not known positively whether the urinary organs are ever affected. These eruptions appear frequently upon the foreskin, head of the penis, the vulva, the vagina and the uterus. They manifest themselves in a variety of forms, sometimes as an erythematous disease, corresponding to the roseolar form of cutaneous syphilis; sometimes as tubercle, corresponding to squamous syphilis, and again as an ulcer, crack or fissure. These three forms may coexist in some cases.

One of the earliest and most common manifestations is erythema of the mucous membrane, which is usually identical with the same eruption upon the skin. It is seen chiefly in the throat, affecting principally the arches of the palate, tonsil, uvula, root of the tongue and pharynx; occasionally, however, it is observed upon the vulva of women who have frequent sexual intercourse, and upon the glans penis of men with long prepuce. It is often so ephemeral and ill-defined as to entirely escape notice. When noticed it usually presents itself in the form of distinct patches, from one-eighth to three-fourths of an inch in diameter, the surface between the patches being healthy; or the eruption may be widely diffused with well-defined borders. The color is red, sometimes copper-color, but there is really nothing distinctive about it. A deposit of lymph sometimes takes place, occurring in small aphthous-looking

specks in patches of considerable size, firmly adherent and of a pale orange color.

Erythema occurs six or eight weeks after the first appearance of the primary sore, although it may be present in a more or less modified form throughout the entire disease. There is usually no great inconvenience arising from it, no soreness in the throat nor difficulty of swallowing; but cases vary greatly, and in some instances there is pain, dryness, and considerable hoarseness. This affection usually denotes but a slight constitutional taint; often disappears quite suddenly, but is very apt to return. Tobacco chewers complain somewhat of pain and smarting when chewing.

Ulcers of the throat are not uncommon, involving principally the posterior portion of the throat, the tonsils and the palate. The deep excavated ulcer, with a hard base, of circular or oval form, looks as if it had been cut out with a punch—it looks in fact like a Hunterian chancre. The surface likewise presents a similar appearance, being covered with a foul, greenish or yellowish lymph, giving it a dirty, unhealthy look. Its most frequent site is one or the other tonsil. The superficial ulcer corresponds in appearance and other respects, to the soft chancre, seldom existing alone, but being multiple, without induration, and possessing well-defined, ragged and undermined edges. Its surface is covered with whitish or yellowish, tenacious lymph. It is usually situated in the pharynx, on the uvula, or on the side of the throat or palate, and is accompanied with much swelling of the parts. Either of these ulcers may become phagedenic or gangrenous, and thus cause rapid and extensive destruction of the parts, difficulty of deglutition and permanent alteration of the voice. While febrile action is not common, it may accompany either form of ulcer; and when the sore is located upon the tonsil, its most frequent site, the swelling may be so great as to greatly impede respiration. Small ulcers sometimes form on the tongue, inside of cheek, etc., and if not accompanied by the characteristic ulcer in other localities or other marks of syphilis, their diagnosis is a matter of considerable difficulty. The history of the case should be carefully considered, and abundant time taken before a positive diagnosis is declared.

Mucous tubercles or patches, as they are usually termed, are found only in syphilis, and make their appearance early in the secondary stage, about the same time as roseola. They come on without much if any pain, occurring generally on mucous membranes, and in the neighborhood of outlets of mucous canals. They appear upon the tonsils, tongue, lips, inside of cheeks, nose, pharynx and larynx, and also upon the body in the natural folds of the skin, where a constant state of warmth and moisture is maintained. So painless are they in the mouth, as a rule, that they are frequently first detected by the physician. The tonsils seem to be a favorite site, and ulceration is more apt to occur here, owing to the constant irritation and friction from swallowing. In women, the

most frequent site is the vulva; in men, the anus and mouth. Mucous patches consist of very slight elevations of the mucous membrane, of an oval or elliptical shape, of a dirty-whitish hue (only rarely red), and of the size of a pea up to that of a silver dollar, or even larger, when several patches run together. They do not seem to be painful, even when pressed firmly between the thumb and finger. When the patches are seated upon the skin, they consist of rounded disks, of a reddish or grayish color, and slightly elevated above the surrounding integument, and are then covered with an offensive muciform secretion, particularly if situated in the neighborhood of the genitals. These patches are then called condylomata. Relapses are very frequent. Mucous patches do not leave scars, unless they ulcerate, which they are very apt to do. Cleanliness will usually prevent ulceration.

Allopathically, these affections are treated locally with *Nitrate of silver*, *Acid nitrate of mercury* and *Nitric acid*, with constitutional treatment according to circumstances. Homœopathic treatment, however, is vastly superior to this. The ulcers in the throat require the same remedies that would be indicated in ulcers occurring on the penis or elsewhere, and hence we need not repeat those indications here. For the gangrenous and phagedenic ulcers, the same is true. For mucous tubercles, there are no remedies equal to *Thuja* and *Nitric acid*, although in rare cases we may be obliged to resort to *Calc.*, *Puls.*, or *Arg. nit.* We invariably use, as a local wash, the third attenuation of the remedy administered internally.

The homœopathic physician should remember that he must be guided in his choice of a remedy by the symptoms present. *Lach.* *Bell.*, *Bry.* or some other drug may be indicated. *Bryonia* cured a case for the author after the failure of other remedies. *Bry.* works well after Mercury in this disease.

TERTIARY SYPHILIS.

Having briefly considered primary and secondary syphilis, it now remains to discuss the tertiary stage, affecting the skin, mucous membranes, periosteum, bones, fibro-cartilages, aponeuroses, tendons and testicles. It may be as well to state at this time that the dividing line between this, the tertiary stage, and secondary syphilis, cannot be accurately determined, as the latter runs gradually and insensibly into the former. It will be found also that some of the affections which we shall mention under this the last stage, do occasionally appear in the secondary stage. It is customary to designate those symptoms which appear before the sixth month as secondary, and those appearing at a later date as tertiary, but this is really too arbitrary a division, as we have already remarked; it is preferable, as far as possible, to divide the disease into stages according to the tissue or parts affected.

The syphilitic poison, we have already told you, may lie dormant in the system for a number of months or even years, and then break out, attacking and destroying with great rapidity various tissues and organs which seems to be its especial prey. Any part of the body may become involved, although the parts mentioned a moment ago are the most frequently attacked. The heart, lungs, liver, brain, kidneys, etc., are not exempt from syphilitic disease, and, in bad cases, a fatal result is to be apprehended. It should be borne in mind, for it is a well-established fact, that occasionally the second stage is skipped entirely, the disease passing directly from the primary to the tertiary stage. It is also claimed and we think truthfully, that this stage is not always preceded by bubo.

The predisposing causes of tertiary syphilis are bad treatment of the former stages—intemperance, abuse of mercury, scrofula, bad hygienic surroundings, debility, and impoverished state of the blood. The inordinate use of mercury is, perhaps, the most important predisposing cause, and in such cases we have the worst possible form of syphilis to deal with; we may say, in fact, that we have two distinct diseases to treat—syphilis and mercurialization. Tertiary symptoms follow both varieties of chancre, but more often the hard than the soft variety. The longer a soft chancre remains uninfluenced by treatment, the more apt it is to be followed by tertiary symptoms. The specific virus is destroyed in this stage, and hence the matter obtained from ulcers, abscesses and other sores is not inoculable.

The diagnosis is comparatively easy when we take into consideration the history of the case, and a host of characteristic symptoms, more or less of which are always present. The main ones are, loss of appetite and strength, eruptions on the skin of a coppery color, ulcers in the throat, paleness of the face when free of eruptions, low spiritedness and melancholy, nocturnal pains, fetid discharge from the nose, enlarged and indurated testicle and impotence. In addition to these symptoms, we also find various local affections which are readily distinguished, and of which we shall speak presently. The important diagnostic points are the history of the case, and the existence of substernal tenderness, which it is claimed is present in the great majority of cases of constitutional syphilis.

The prognosis is always serious, for, at most, we can only promise a certain degree of relief, although cures do take place with some disfigurement, as the loss of a nose or palate, extensive scars, etc. There is always some reminder of the disease left.

When secondary symptoms are light, or when tertiary symptoms come on very early, we fear syphilis of the brain and spinal cord, which, although of comparatively rare occurrence, is sometimes seen in hard drinkers, sedentary persons, and those who have had much mental anxiety or some previous nervous affection. Syphilis of the nervous system has received considerable attention and study the past five years, and although not perfectly understood, we are still in a position to intelligently treat all such cases. Men are more prone to nervous affections than women, and are affected at any time from six months to twenty years after infection. The brain is more frequently affected than the spinal cord—in fact very little is known concerning syphilis of the cord. Paraplegia is, however, the leading symptom of the latter.

Bumstead states that "the nervous phenomena of syphilis generally originates in lesions developed in one or more of the following structures: 1. The cranial bones and vertebra; 2. The dura mater; 3. The arachnoid and pia mater; 4. The brain and cord; 5. The arteries; 6. The nerves." These nervous phenomena may be due to (1) inflammation of the brain caused by the presence of nodes, caries, necrosis; (2) to thickening of the dura mater, this membrane being peculiarly susceptible to the syphilitic influence; (3) to congestion of the arachnoid and pia mater, with thickening of their membranes or gummatous infiltration; (4) to red or white softening of the brain and cord; (5) to interference with the circulation of the blood caused by thickening of the coats of the vessels and deposit of white blood corpuscles along their inner walls; (6) to compression of the nerves by swellings, to neuritis or perineuritis, or alterations in the texture of the nerve.

The symptoms of syphilis of the brain depend greatly on the locality of the lesion. If situated in the cranial bones or meninges, intense, per-

sistent headache with nightly aggravation, is a prominent symptom, but vertigo, sleeplessness, delirium and photophobia, are not unusual. This headache is frequently limited to one-half of the head, although it may shift its position. The symptoms are of a most varied character depending upon the amount of structure involved, and the degree of pressure upon the surface of the brain. Mental imbecility, epilepsy and paralysis are caused when the arachnoid and pia mater become thickened and indurated or infiltrated with a gummy deposit. Coma, convulsions, paraplegia and hemiplegia are almost always the result of excessive doses of mercury. Very often the diagnosis can only be made by the process of exclusion and by the history of the case. The prognosis is not as grave as in other similar maladies, for it has been found that the gummy nodules found in the substance of the brain, the caries and necrosis of the skull-bones, and other evidences of disorganization are wonderfully affected by remedial agents. For instance, *Sil.*, *Aurum*, *Nitric ac.*, *Fluor ac.*, *Hepar*, etc.

Tertiary affections of the mouth and throat are very common. They manifest themselves as scaly patches due to epithelial thickening, resembling icthyosis, but cannot be scraped off as they bleed readily on being touched, or as characteristic ulcers, which, if not arrested, gradually spread to the maxillary and palate bones, destroying everything in their way, even the bones, so that the buccal and nasal cavities become one. In all such cases the voice becomes greatly altered. *Aurum*, *Sil.*, and *Nit. ac.* have served us best in such cases, as they have also in tertiary syphilis of the tongue. This form appears in a similar way in the shape of scaly patches, or as ulcers situated upon the sides of the tongue at or near its middle, and are of considerable extent and depth. The base of the ulcer has a hard feel like that of a chancre. The diagnosis is sometimes quite difficult unless the history of the case can be obtained. In some cases it has been confounded with cancer.

In a certain proportion of cases the teeth become affected in tertiary syphilis, as is shown by the crown gradually separating from the fang. It is still an open question whether syphilitic erythema takes place in the intestines, but it is generally conceded that it does. At any rate we are positive that ulcerations of a syphilitic character occur in a certain proportion of cases, affecting principally the colon and the small intestine, near the illeo-cæcal valve. They may occur also in the stomach, and are manifested only by indigestion and pain in the epigastrium. The diagnosis of intestinal ulceration can be made only by the existence of long-continued diarrhœa or dysentery, which does not yield to ordinary treatment, by the existence of well-marked syphilitic lesions elsewhere, and the history of the case. In one case which came under our observation, but not under our care, the dysentery resisted all treatment for a period of ten months, and death was the result. Excessive doses of

mercury, we believe, is a predisposing cause of this complication, and *Nitric acid* is our most valuable remedy, although often *Merc. cor.* high, acts well. *Aloes* in one case relieved greatly. *Sulphur* should not be overlooked.

Ulceration of the nasal mucous membrane may occur as a secondary or tertiary manifestation, and even as a primary disease, the chancre sometimes appearing here first. We shall, however, confine ourselves to the third stage, merely remarking in passing that secondary ulcerations are recognized by the copious, bloody and purulent discharge, which is persistent. In tertiary ulcerations, or syphilitic ozæna, as it is frequently called, a very disgusting and offensive disease, there is a similar discharge, but it is very fetid. The voice is altered, becoming muffled and nasal. This variety is slow and insidious in its progress, involving eventually the cartilaginous and osseous structures, and the ulcerative process may perforate the septum or the floor of the nasal cavity, or destroy the entire nose, unless soon arrested. The sense of smell is usually destroyed, and the taste somewhat impaired. Pain at night may or may not be present. When the cartilages are destroyed, the tip of the nose is flattened and depressed; when necrosis of the nasal bones occurs, the tip is elevated. After a cure in these cases, the bridge of the nose is permanently sunken, giving a peculiar appearance to this important feature of the face. *Aurum* is by far the most important remedy in these cases, although *Nitric acid*, *Sil.*, *Hepar*, and other remedies have been successfully employed. *Nitric acid* should be given if the patient has already taken mercury in large doses.

The mucous membrane of the larynx is not unfrequently affected in the secondary and tertiary stage. In the former, as erythema, superficial ulceration, mucous patches and chronic inflammation with hypertrophy of the mucous membrane—in the latter as deep ulcerations, gummy tumors, perichondritis and necrosis. The tertiary lesions seem to be more common and occur from two to eight years after the primary sore. The symptoms of laryngeal syphilis are very deceptive and not in proportion to their gravity. A superficial ulcer may be complicated with œdema threatening life on the one hand, and on the other the cartilages may be partially destroyed without the patient being aware of anything serious. It is unnecessary to here mention the secondary manifestations, as they are similar in appearance to those situated on other mucous membranes. Suffice it to say that the inflammation or ulceration pursues a very chronic course and is quite difficult to cure. In the tertiary form, the vocal cords, the arytænoid cartilages, and the epiglottis become involved, and are finally destroyed by the ulcerative process. Frequently, instead of ulceration, the mucous membrane becomes covered with a number of gummy tumors of a red, fleshy appearance, of the size of a mustard seed or small

shot, and are usually most abundant about the vocal cords. These tumors often degenerate into deep, ragged ulcerations, which may eventually impede respiration and destroy life. The tracheal rings are sometimes necrosed and thrown off, and suffocation may result from œdema of the glottis, or even from the attendant ulceration.

The symptoms present in syphilitic disease of the larynx are not uniform in degree; pain may be entirely absent, or there may be painful and difficult deglutition, especially on swallowing fluids, at which times the patient may be threatened with suffocation. Pain in the ear of the affected side is usually complained of. The voice may be hoarse and husky for months, and in time is either completely lost or reduced to a mere whisper. Cough is always present to a greater or less extent, the expectoration being scanty, or copious, fetid, bloody, and sometimes mixed with fragments of cartilage or bone. The larynx is frequently tender on motion and pressure; copious and exhausting sweats are not uncommon; emaciation and debility follow in due course of time, and the patient may die of exhaustion, suffocation or even hemorrhage from the ulceration of some one of the laryngeal arteries.

The diagnosis is rarely attended with difficulty when we take into consideration the history of the case, the symptoms just enumerated, and the presence of syphilis in other portions of the body. The prognosis should be guarded, as œdema of the glottis is a frequent and dangerous complication. The remedies best suited to this variety of syphilis are *Lach.*, *Carbo. veg.*, *Ars.*, *Sil.*, *Hep.* and *Nit. ac.*

Syphilis affects the lungs but rarely, and usually presents itself in the form of gummy tumors, six or eight in number, of a dirty white or grayish color. These tumors resemble those of other organs. The symptoms of pulmonary syphilis are identical with those of chronic phthisis, viz.: night-sweats, cough, emaciation, shortness of breath, etc. The diagnosis would be impossible without a history of the case or the presence of other evidences of syphilis. *Carbo. veg.* was the only remedy we used in the case of a physician, and a complete cure was the result. The disease had lasted several months. *Nit. ac.*, *Hepar.*, *Sil.* and *Sulph.* have also proved valuable.

The bronchial tubes are also sometimes the seat of syphilitic ulcerations. The prognosis is unfavorable in all cases, for cicatrization of the ulcer leads to contraction and stricture, and the same is true of the air-passages generally. The remedies mentioned above may be given, and some relief will be experienced, if not a cure.

Deafness may occur early in syphilis as a temporary ailment, but later in the disease it is apt to be permanent. It is sometimes produced by syphilitic growth of the external meatus, at others by a mechanical obstruction of the pharyngeal openings of the Eustachian tube, or by the remains of a soft palate becoming adherent to the pos-

terior and lateral walls of the pharynx. Syphilis of the ear is of rare occurrence, about one-half of one per cent. of all cases, and is not as well understood, particularly when affecting the inner ear, as when affecting other organs of the body. It occurs, when not hereditary, in intemperate persons, and makes its appearance in the form of sudden deafness, the result of catarrhal inflammation or other causes, accompanied with more or less pain, or at least a sense of fullness in the ear. Both ears are usually affected at the same time, but not invariably. This inflammation may result in ulceration and destruction of the tympanum, and consequent deafness, which is permanent. In bad cases, the Eustachian tube, the middle ear and even the bones, not only of the ear, but the petrous portion of the temporal, also, become involved. The diagnosis is based entirely on the history of the case, as there are absolutely no other diagnostic symptoms in most cases. *Ars.* *Aurum*, *Hepar*, *Nit. ac.* and *Sil.* are useful.

Iritis is the most common, as well as the most serious affection of the eye developed in the course of syphilis. It is generally claimed that more than one-fourth of all cases of iritis are of syphilitic origin. It may be either acute or chronic, and occurs either as a secondary or tertiary manifestation after exposure to cold, even in strong and otherwise healthy people. It is usually associated with papular, tubercular or pustular eruptions, ulcerations of the mucous membranes, rupial sores or rheumatic pains in the bones. This affection will be recognized by a peculiar vascularity around the cornea and of the iris, by the fixed and contracted pupil and its displacement upward and inward. The iris is changed in color, and is covered with reddish-brown tubercles or minute yellow abscesses. Accompanying these changes is pain, either slight or severe, deep in the eye, forehead and temples, with nightly exacerbation. The disease is not limited to one eye, but almost invariably attacks both simultaneously or successively. It sometimes see-saws from one to the other eye. The disease rapidly extends to the cornea, retina and other structures of the eye, and if not speedily arrested usually results in impairment of or total loss of sight. Surgeons have laid down certain definite symptoms for rheumatic and syphilitic iritis, when in fact there are no certain means of distinguishing them, aside from the connection of the one with rheumatism and the other with syphilis. In rheumatic iritis often only one eye is affected, while in the syphilitic variety it is first one and then the other; the pain in the former is nearly constant, with slight aggravation at night; in the latter the pain is variable, slight or very bad at night, but absent during the day. The exceptions make the diagnosis difficult.

As regards the treatment of this serious complaint, mercury is recommended by both schools, and if the pupil does not dilate rapidly, atropine locally. When tubercles or small warts appear on the iris

Thuja may be used to advantage, although some physicians prefer *Nitric acid*, especially if the patient has had a thorough course of mercury. *Cinnabar* is valuable in scrofulous individuals. *Hepar* is necessary if pus forms. *Aurum* is indicated in advanced cases of tertiary, with a disposition to commit suicide.

Ulcers of the skin or rupial sores (to which we have already briefly referred), may be met with in the secondary stage, but usually they make their appearance late in the tertiary, and hence should be at least mentioned in this place. These ulcers are accompanied by nodes, rheumatic or bone pains, or with ulceration of the throat, nose and larynx, or with all these ailments combined, or may result from pustules, tubercles or boils. At all events, they are usually preceded by papules, pustules, tubercles or scaly eruptions. These sores appear only in those with broken-down constitutions, and show intense syphilitic infection. They make their appearance most frequently on the extremities, or where the integument is thin, or where they are moistened by the secretion of the part, and occasionally on the scalp, forehead and temples. They vary greatly in size, being as small as a split pea or as large as a cut melon, or even larger when several run together. Their shape is usually circular or oval, and they tend to spread in circles. The edges are callous, elevated and ragged, often everted; the surface is covered with a foul grayish or greenish matter, the discharge being thin, ichorous, offensive and often profuse. They are sometimes painful to the slightest touch, but not usually. The ulcers are generally superficial, the depth being about one-half the thickness of the integument, although they do in rare instances penetrate to the muscles and bones. Their duration is usually chronic when not influenced by medicines. They continue for some time; at certain intervals creeping along slowly and eating deeply, at others healing, and again at others showing no appreciable change for days at a time. They may become phagedenic, gangrenous, etc., the same as the primary sore.

Febrile action is not uncommon during their existence, although it is slight. The patient complains of being tired and weak, has no ambition, no appetite and an uneasy, unrefreshing sleep; his bowels are costive; his skin is dry and hot; his pulse small and somewhat accelerated; his appearance is that of an old man; frequently suicidal thoughts enter his mind. The scars left by the healing of the ulcers are at first brown or bluish and finally very white, puckered in the center. They are prone to re-open from the slightest irritation.

The diagnosis is usually easily made, for the ulcers present a chancre-like appearance, with the copper-colored areola, and, in addition, we find other evidences of syphilis present in the great majority of cases.

As regards the treatment, we shall mention *Asaf.* when the ulcers are very sensitive to the touch.

Lachesis for bluish appearance of, and gangrenous ulcers.

Arsen. for phagedenic ulcers.

Sil. for penetrating ulcers, with thin, offensive discharge.

Aurum for suicidal tendency.

Nitric acid, *Mercurius*, *Carbo. veg. Ars. jod*, and other remedies may be called for in special cases.

The nails are sometimes attacked by syphilis. The various eruptions we have described, may occur upon the fingers and involve the nutrition of the nails. Onychia or inflammation of the matrix is a common result in such cases, and the nails become dry and black and drop off, leaving an ulcer. Or there may be destruction of the nail without ulceration or without inflammation of the matrix—this, however, is very rare. Not all of the nails of a hand or foot are attacked—usually not more than two or three altogether. There is no pain, as a rule, although the affection continues a long time. In exceptional cases, the pain is intense, and runs up the arm. If the disease is not speedily arrested, the matrix is apt to be completely destroyed, and the nail, of course, never forms again. When the matrix is not destroyed, the nail grows again, perhaps normally, but usually distorted in various ways. Consult *Aur.*, *Ant. c. Ars.*, *Caust.*, *Graph.*, *Hep.*, *Merc.*, *Sil.*, *Sulph.*

Tubercles, or gummata as they are termed, are liable to form where the sub-cutaneous cellular tissue is loose and abundant, during the progress of tertiary syphilis (rarely earlier than this stage), especially in enfeebled persons or those of broken-down constitutions. Gummata are essentially syphilitic indurations of the connective tissue, varying in size from that of a pea to that of an orange, and in number from one to six. These tumors are of slow growth; they are painless, but slightly tender to the touch; they have a firm, semi-elastic feel, retaining their shape under firm pressure, and they are hardly ever situated near together, but are widely separated. When located just beneath the skin, they have a deep reddish-brown color previous to suppuration. They are movable at first for a period of several weeks or months, but gradually contract adhesions to the surrounding skin, and eventually suppurate and ulcerate if uninfluenced by internal treatment, discharging a honey-like or thick gummy matter, with a slight admixture of bloody pus. After the discharge, a cavity, circumscribed by a cyst, remains, or an ulcer resembling a chancre, which may become phagedenic, gangrenous, etc., the same as the primary sore.

As one crop of these tubercles disappears, it is usual for another to take its place, and thus the disease may be prolonged for a number of years. The tubercles consist of fibro-plastic matter, small nuclei and fatty granules, intermixed with amorphous substance. Quite frequently gummata form in the muscles and tendons, and in the viscera as well.

Gummata of the muscles and viscera are usually preceded by disease of the bones, but not invariably. The diagnosis is easily made, as a rule.

The treatment consists in building up the system, prohibiting alcoholic stimulants and administering such remedies as *Hepar*, *Nitric acid*, *Sil.*, etc.

Lesions of the periosteum and bones are almost always preceded by a series of superficial secondary symptoms, and do not usually declare themselves until very late in the tertiary stage, that is from two to four or more years after the primary sore, although we may find bone pains previous to the cutaneous eruption, or may have nodes in secondary syphilis, but they are simply a sub-periosteal œdema and hyperæmia, and disappear promptly under treatment. Mauriac asserts that the bones may be affected even before the appearance of cutaneous eruptions; but this opinion is not generally indorsed, except when the disease is hereditary. Affections of the osseous system are met with only in scrofulous or intemperate persons, or in those who have been actively treated with mercury. We thus see another form of syphilis which can often be laid at the door of this poisonous drug, notwithstanding many of our allopathic friends deny that mercury ever causes bone disease. Truly, the remedy is worse than the disease. Mercury administered even in small doses and continued for some time, deteriorates the system and renders it more prone to take on a low grade of inflammation, and this is particularly true of its action on the osseous system.

The limit of lesions of the bones cannot be assigned—they are liable to last as long as the syphilitic diathesis continues. This form of tertiary occurs as nodes or soft tumors, inflammatory hypertrophy, exostosis, caries and necrosis. The bones usually affected are the superficial ones, as the tibia, fibula, ulna, clavicle, palate, nose, upper jaw and the bones of the skull, although in exceptional cases almost every bone in the body becomes affected.

A node is a gummy formation, and may be defined as an inflammatory osteo-periostitis, terminating usually in a new formation of bone. Nodes occur generally on the tibia, ulna, clavicle and skull. They are of a rounded or elongated shape, semi-solid, elastic and somewhat painful to the touch, and from a quarter of an inch to two inches in diameter. They begin beneath the periosteum upon the surface of the bone, to which they are attached, as an inflammation, followed in a few days by the deposition of a gummy substance of a greenish hue, often mixed with pus, or the gummy substance may be entirely wanting, and the tumor composed entirely of pus. This tumor should never be opened, as it may undergo resolution at any time under appropriate treatment. Even in cases where it seemed on the point of bursting through the thinned skin, this has happened. Not only the periosteum, but the bone, likewise, is inflamed, softened and ulcerated, and, as the tumor grows, it

involves the structures above, which become reddened and painful. If opened artificially or otherwise, the discharge consists of a gummy substance mixed with pus, or of pus alone.

A node is really an abscess of the fibrous and osseous tissues. Its course is always indolent, and the pain which accompanies it is of a neuralgic character, greatly aggravated at night. This pain in most cases is only present at night, and seems to be occasioned by the heat of the bed, for if the patient from any cause fails to go to bed and remains up all night, the pain does not come on. In a night watchman the pain came on when he went to bed every morning. After a node ulcerates, it shows but slight tendency to extend, but it may become gangrenous, phagedenic, indolent, etc.; in other words, it may take on any kind of action common to syphilis. Sometimes a node will remain as a hard, fibrous swelling, perfectly painless, for a number of years, causing the patient but slight inconvenience, but at any time it may suddenly soften and involve the bone in destruction. After a node ulcerates, the floor is bone denuded of its periosteum, which soon becomes black, and necrosis occurs. Scars are always left to tell the tale, and they are white, puckered, attached to the bone, and often pigmented at the circumference.

The diagnosis is not difficult, as the appearance of the swelling, the course of its growth and the nocturnal pains are characteristic. The treatment consists in the use of one of the following remedies:

Asaf., nodes very sensitive to the slightest touch,

Nitric acid or *Kali. jod.*, after the abuse of mercury.

Hepar or *Sil.*, during the suppurative stage.

Ars., *Lach.*, *Carbo. veg.*, for phagedena or gangrene.

Mezer., *Staph.*, *Phos. ac.*, for intense pains in the periosteum.

Fluor acid, burning, intermittent pains in the bones.

Caust., excessive physical depression and loss of strength.

Plumb., *Plat.*, *Phos.*, *Puls.*, *Petr.*, *Sulph.*, *Lyc.*, *Natr. m.* and *Ars* should also be carefully studied.

Dry caries, which is characterized by the entire absence of suppuration, occurs late in syphilis, and is recognized by intense localized pain without swelling. The parts affected are the flat bones, as the frontal and parietal, sometimes one table only and at others both. It is caused by gummy deposits in the outer sheaths of the vascular supply, or by a cutting-off of the nutrition of the part by an inflammation and degeneration of the vascular periosteum. The disease occurs only in those of advanced age. Caries, or ulceration of the bone, affects principally the tibia, ulna, palate, maxillary, turbinated and ethmoid bones, and presents itself in different forms, viz.: As the simple ulcer, serpiginous ulcer, or as worm-eating caries. It is denied that caries is strictly syphilitic, but is due entirely to a development of the scrofulous diathesis. Caries is usu-

ally conjoined with necrosis, although it may exist alone. In some cases as we have already remarked, the mouth and nose communicate, the intervening structures being totally destroyed.

Necrosis or death of the bone usually follows caries, especially in the thin bones of the nose, palate, etc., but it also occurs in the cranial and jaw bones in very many cases.

Hypertrophy, or hyperostosis, may implicate any portion of the osseous system, although it usually affects the superficial and long bones. It is occasioned by the deposition of gummy tubercules in the medullary canal, and in the substance of the bone itself. The surrounding tissues exhibit no sign of inflammation, but the part affected becomes greatly enlarged, a solid osseous substance is substituted for the spongy matter, the medullary canal is obliterated and the bone becomes similar to ivory in texture. The symptoms present are few in number, viz: The characteristic nocturnal pains and neuralgic pains of varying intensity at all times in the muscles and tissues in intimate connection with the diseased part, with an increased feeling of weight in the limb.

An exostosis originates in a plastic periostitis, and is the same thing, but usually does not affect but a small portion of the bone, the tumor being of variable size, knotty and irregular with a broad base. The tumor or tumors may at first be movable upon the bone beneath, but after a time, if resolution does not occur, becomes attached and a part of it. When an exostosis springs from the inner surface of one of the cranial bones, it gives rise to very serious symptoms, terminating frequently in convulsions and paralysis. In deep-seated regions where direct exploration cannot be made, exostosis can only be suspected from the history of the case. When the tumor becomes eburnated, no internal treatment is of avail, and surgical interference may be necessary.

The cartilages are sometimes attacked by gummy infiltration as well as the bones, particularly the cartilages of the larynx, and necrosis may be the result. We have already spoken of this.

Mercurius is recommended for exostosis, but as patients thus afflicted have usually taken large doses of mercury, we find *Nitric acid* a more useful remedy for this as well as for other bone affections.

Aurum is valuable when the bones of the face, nose or skull are affected. Suicidal tendency.

Sil., *Kali. jod.*, in scrofulous persons. Ulceration of the bones with fistulous openings; inflammation of the periosteum.

Fluor acid, burning and intermittent pains in the bones. Imaginary fears; ill-humored.

Phos. ac., intense pains in the periosteum of all the bones as if scraped with a knife; low-spiritedness.

Asaf., violent pain in the bones, and discharge of fetid, thin, ichorous pus; crampy jerking and drawing in the bones at night.

Hepar, swelling or inflammation of the bones.

Mezer., tearing and burning pains in the bones; dark, turbid urine.

Petr., brown spots on the wrists; skin ulcerates easily; fetid urine.

Rhus. Rheumatic pains aggravated on first moving after rest and on getting up in the morning. Worse during rest, better from continued motion; paralysis of lower limbs; warts on various parts of the body.

Staph., caries, particularly of the teeth; pressive pains in the periosteum; confusion of the intellect.

The joints are occasionally involved in both secondary and tertiary syphilis. Specific inflammation may attack the articulations at the outset, or by the extension of an osteitis from the articular extremity of the bone. It occurs in weak, ill-fed and ill-clothed persons. In secondary syphilis, synovitis is attended by pain, fever, sweat, etc., much resembling in its general symptoms acute articular rheumatism, but the affection begins slowly and painlessly. There is always effusion into the joint, but there is an intermittent character to this effusion, the fluid sometimes appearing and disappearing rapidly, to again re-appear, or it may make its appearance slowly and as slowly go away; but in either event, it is very prone to re-appear from very slight causes. There is no tendency to suppuration or to destruction of the joint. The synovitis of the tertiary stage, however, is attended with lesions of the joint structures. The synovial membrane becomes thickened and incrusted with gummy matter, while its cavity contains a turbid, viscid fluid. Stiffness of the joint and of the surrounding muscles and structures is complained of, especially on motion in the morning. The pains are usually worse at night and in wet weather. The character of the pain is dull and aching, seldom tearing or burning. Aside from the deposit in the synovial membrane, there is usually a gummy infiltration in the muscles and other structures about the joint. The knee, elbow and wrist joints are the parts most liable to be attacked, although in rare cases hardly any joint is exempt.

The disease may remain stationary for years. There is but slight tendency to complete anchylosis. Unless the syphilitic antecedents of a white swelling are known, the diagnosis is impossible, although we know that its onset is insidious, and that it pursues an indolent course. Consult *Bry.*, *Rhus.*, *Caust.*, *Asaf.*, *Led.*, *Merc.*, *Stict.*, *Sil.*, *Sulph.*

The urinary organs are not entirely exempt from the ravages of syphilis, but as yet the lesions are not very well understood, and their diagnosis is often a matter of considerable difficulty. Gummata are rarely met with in the kidney, but when found they seldom exceed the size of a pea. Deposits in the kidney are always associated with similar deposits in the liver and spleen. As a rule, there is no local pain or general fever, and the existence of the disease is surmised only by the

presence of albumen in the urine and the history of the case. It should be remembered, however, that the urine is not always albuminous, and then the diagnosis cannot be made, except by a post mortem examination.

Syphilis of the ureter and prostate does not seem to occur, neither does syphilis of the bladder, except in connection with disease of the spinal cord. The spermatic cord is sometimes the seat of gummy deposits.

Gummata occur in the corpora spongiosum, and in the corpora cavernosa in very rare cases as a hard, painless nodule without redness. It has a semi-elastic feel when pressed between the fingers. If seated on one side, it causes deflection of the penis when erect toward that side; but if it assume the annular form, the penis, during erection, is turged from the crura to the seat of the lesion, but beyond that is flaccid and hangs at right angles to the rest of the organ. The tumor reaches a certain size, and then may soften and shrivel away, or possibly may become fibrous. A patient under treatment now who has been treated with the *Iodides*, *Mercury*, etc., besides the local application of *Iodine* is steadily improving under the administration of *Conium*.

Syphilis of the testicle, known under the name of syphilitic sarcocele, orchitis or albuginitis, makes its appearance from two to fifteen years after the primary sore, and is usually accompanied by some form of tertiary, as periostitis, exostosis, ozæna, or ulcers in the throat, although in rare instances it is the only manifestation of syphilis present. It always denotes a low state of the system. Exceptionally, in malignant cases, orchitis may be developed in a very few months. The exciting cause of this form of syphilis may be a blow or other injury of the parts. The disease generally involves both testicles, either at the same time, or first one and then the other at variable intervals. In some cases, the scrotum remains healthy and non-adherent, in others the disease eventually extends to the epididymus, forming one inseparable mass of the two structures. Usually there is an entire absence of pain and an insensibility to pressure. To the touch, the testicle resembles a stone or block of wood, with slight knobby projections. Toward night the testicles feel very heavy, and if left hanging unsupported, occasion a dragging sensation in the spermatic cord, but there is no real nocturnal exacerbation as in bone disease. There is usually a slight aching pain in the small of the back. The testicles not only become heavier and harder, but are greatly enlarged, sometimes becoming three times their natural size. The surface of the tumor, which preserves the normal shape of the testicle, is usually smooth, only rarely knobby. In advanced cases, the spermatic cord becomes involved, and is hardened and thickened. In malignant cases, fortunately very rare, tubercular deposits occur, which terminate in the formation of ulcers and in the production of fungi. The course of orchitis is exceedingly slow and chronic. The sexual desire is greatly diminished, or entirely lost. Orchitis is of occasional occurrence

in inherited syphilis. The affection terminates in resolution or in fibrous atrophy, and, as we have already stated, in ulceration in bad cases. Early and persistent treatment will restore the parts to their normal condition.

The testicle has frequently been amputated, under the supposition that the affection was of a cancerous nature. In cancer, pain is a prominent feature, but not in orchitis. The diagnostic points are absence of pain, insensibility to pressure and a syphilitic history. As regards treatment, we have found *Conium* of very great service—in fact, it is the most important remedy. *Clem.*, *Puls.*, *Nit. ac.* and *Lyc.* are also useful. *Hepar*, in cases with ulceration. The remedy should be chosen according to the totality of the symptoms. *Spongia* has proved curative in several cases—in one the testicle was four times its natural size. A sailor was greatly benefitted by *Aurum*, but was lost sight of before a cure resulted.

Impotence, as we have shown, is sometimes due to orchitis, but in other cases it may come on independently of any cachexia, or may be due to some impression upon the nervous system.

Syphilitic ovaritis is not uncommon, and is apt to be associated with gummy tumors in the breast. The only symptom is painless swelling of the organ.

The rectum is frequently involved in syphilis, either through chancres situated near the margin of the anus, or through secondary or tertiary ulcerations within the gut. In either event, stricture of the rectum is usually the result. The patient complains of a great desire to go to stool, with pain in the rectum, attended by an excessive discharge of pus and bloody feces. Constipation is rare, and is present only at the commencement of the ulceration, or in very exceptional cases. As a result of this constant losss of blood, the patient becomes weak, loses flesh and suffers from gastric difficulties. We have never seen these rectal ulcerations in men, and hence infer that they are much more common in women. The stricture when present yields to the influence of properly selected remedies, such as *Nitric acid*, *Phos. acid*, *Caust.*, *Hepar*.

Syphilis attacks the liver more frequently than any other of the viscera; in secondary, in the form of congestion, with icterus; in tertiary, as chronic interstitial hepatitis, as gummata, or as amyloid degeneration. The symptoms of chronic hepatitis are those of ordinary cirrhosis. The diagnosis of gummata is very difficult and often impossible. Pain, if present, does not extend to the shoulder, as in other affections of the liver. Blood may be expectorated and passed with the clay-colored stools; epistaxis is not uncommon; icterus is present in a certain proportion of cases; the skin is dry and cool. The symptoms of amyloid degeneration resemble those of cirrhosis. Treatment promises but little, except in gummata of the liver, when such anti-syphilitic remedies as we have frequently mentioned may be administered.

HEREDITARY SYPHILIS.

The terms congenital and infantile have been used, and are still used, to designate this form of syphilis. The term congenital should be employed only where a child is infected during labor; and as the term infantile means simply syphilis of children, it is better and more accurate to call this division of our subject hereditary syphilis. Hunter denied the inheritance of syphilis, but at the present day his opinion is not accepted. It is true that we are still ignorant of the amount and nature of the constitutional affection of the parents that is necessary for the development of syphilis in their children; but we are not ignorant of the fact that it is possible for syphilis to be transmitted by inheritance. There is a vast difference of opinion as regards the etiology of this form of syphilis, and we can in this lecture give you only a brief summary.

Arbitrary rules regarding the parental influence in the transmission of syphilis unfortunately cannot be laid down, and, as a matter of fact, there are two sides to almost every question which we shall discuss. We are certainly not warranted in concluding from our present knowledge that a parent who has been, or even who is, suffering from constitutional symptoms will necessarily procreate a syphilitic child. The vexed question, and one which seems as far from solution as ever, is: Does the child derive its disease solely from the father, the mother being healthy?

Some authorities assert, and others deny, that the father can communicate the disease to the offspring. Cases are reported showing: 1st. A syphilitic father, and a healthy child. 2d. A syphilitic mother and a healthy child, and even, 3d. Both parents syphilitic and still a healthy child. It may be stated as a general rule, however, that when both parents are syphilitic the child will be affected. And this rule usually holds good, even after the disease has become latent in the parents, that is, even after they seem to have entirely recovered. In course of time syphilis wears itself out or is relieved by treatment and the offspring escape infection. Parents suffering from active syphilis are not able to raise the child—it dies in a few weeks or months—or more often still, the fœtus fails to reach maturity. A child born of parents in whom the disease is on the wane, or greatly modified by treatment, shows usually but slight evidences of the malady, and it is stated and believed by many authorities that after six years the risk of transmission is

extremely slight. M. M. Fournier and Barthelemy, of the St. Louis Hospital, Paris, quote two cases showing that the taint of syphilis may be transmitted to the offspring twenty years after the disappearance of all symptoms of the disease. Such cases are very uncommon, and it is likely that in such instances the disease had been suppressed by active treatment, not cured.

It is a fact known to all who have thoroughly investigated the subject that there are certain periods of repose in this affection—of longer or shorter duration—and during these intervals it is possible that healthy children may be born. For instance, the first, third and fifth child may be healthy, whereas the second and fourth may be diseased. In other words it may be said that when there is no venereal manifestation the child procreated runs but slight risk of being infected. But arbitrary rules cannot be laid down, and the statement, while it may be true as regards the father, is not as certain as regards the mother, who may bear syphilitic children at any time and under all circumstances. There are so many peculiarities about the transmission of syphilis by inheritance that one can hardly make any statement that cannot be proved or disproved by numberless cases. Syphilis tends to exhaust itself, and, as a general rule, the children become less and less diseased as time goes on—that is, with syphilis—but scrofula may take its place.

There can be no possible doubt that when the mother alone is syphilitic the child is quite certain to inherit the disease, except during the intervals of repose already referred to. The ovum being a part of the mother, whose fluids are poisoned, it is almost a matter of necessity that it should develop into an unhealthy child. Syphilis, it should be remembered, while occasionally a mild disease in women, generally affects them more profoundly than men. Hence, there are numerous exceptions, owing to this occasional mildness, and to the intervals of repose, and a syphilitic mother may bring forth a healthy child. Cullerier, Notta, Adam Owre, Sturgis, J. W. Thompson, Mireur, Follin, Charrier and others contend that syphilis is always inherited from the mother alone. A peculiar fact, if fact it be, difficult of explanation, is, that a perfectly healthy woman having a syphilitic husband, and bearing syphilitic children, should, upon a subsequent marriage to a perfectly healthy man, continue, for a time at least, to bear syphilitic children. It is impossible to account for it, except upon the supposition that the semen makes a permanent impression upon the ovaries, or that the disease is masked in the woman.

When the father alone is syphilitic, the child usually escapes if the mother remains well. Nearly all authorities admit that the father is less liable to transmit syphilis to his child than the mother; but very few deny that he does exceptionally transmit it. Caspary, Keyfel, Van Harlinger, Trousseau, Mayer, Kassowitz, Bumstead and others ascribe equal

if not more power to the father than to the mother in transmitting the disease. They believe in the main that the father alone—the mother being sound—may be the cause of syphilitic offspring, and that the mother, if healthy at the time of conception, may remain so. Every practitioner knows of scores of cases, if he has paid especial attention to syphilis, where a diseased father and a sound mother have given birth to perfectly healthy children; but he does not remember more than one, or possibly, two cases, where a sound father and a syphilitic mother produced healthy children. When we look at the vast number of young men, who are, or have been affected with syphilis, the rarity of diseased children is surprising, if we adopt the theory of transmission from the father. And yet we have evidence sufficient to prove that exceptionally the father is the cause of the syphilitic child.

It is a well-known fact that in the higher walks of life, syphilitic children are a rarity, and yet comparatively few young men of this class escape contagion. In the lower walks of life, the women are not so virtuous, and syphilitic children are quite common, hence adding weight to the opinion that syphilis is derived entirely from the mother. Henock observed the birth of a syphilitic child twenty years after the infection of the mother.

It has never been conclusively shown that a healthy mother who had given birth to a syphilitic child, diseased from its father, afterward became herself poisoned by experimental or accidental inoculation. Colles states that a child with inherited disease may poison a healthy stranger whom it suckles by inoculating the breast, but that the same child never locally infects its mother. If we accept this statement, we are obliged to conclude that the mother is already affected. He also holds the opinion that the disease may be communicated to the nurse by mere contact without the presence of an abrasion or crack upon the nipple. We have seen one instance of this where the most careful scrutiny failed to discover any abrasion, and yet the diseased child communicated syphilis to the nurse, in this instance its aunt. Caspary found a seemingly healthy woman with a syphilitic husband and a syphilitic child, and he inoculated the woman with the specific virus without effect. Thus the woman, although apparently healthy, probably had a mild form of syphilis. We say probably, because inoculation does not always succeed any more than vaccination does.

The date at which a pregnant woman may become syphilitic without poisoning her child is after the seventh month. If she gets chancre at the moment of conception, or soon after, she is apt to miscarry. If she gets it later, the child goes to term, but is born thoroughly poisoned, with a poor chance of surviving. The common agreement is that if the chancre does not appear before the seventh month, the child is safe, but there are numerous exceptions. Bumstead takes the ground that the

syphilitic virus of the mother cannot be conveyed through her blood to the child, for the reason that the essential vehicles of the specific virus are cells or albuminoid molecules, derived from an active syphilitic lesion, and the embryo is not supplied with cells of any kind after fecundation. So that a syphilitic child, born at full term of a mother infected at some time during gestation, is poisoned by the father. For the same reason, he contends that a healthy mother can bear a syphilitic child, the immunity of the mother depending on the absence of cellular elements in the fluid interchanged.

Ricord speaks of this mode of infection, and calls it *choc-en-retour*. He contends that a healthy woman may conceive by a syphilitic man, and the ovum become diseased through impregnation with diseased semen, and in its turn poison the mother, the latter never undergoing chancre, but becoming directly contaminated by contact of her fluids with the infected fluids of the fœtus, thus giving the mother the modified form of the disease. The semen nowadays is not supposed to contain the specific virus, but we do not believe a great many cases could be explained if we deny that it is ever the source of contagion.

The transmission of syphilis to the third generation has been generally doubted. Most authorities believe after it has once been transmitted by inheritance it degenerates into scrofula, which, in its turn, may be transmitted. The probable reason that cases are not met with is that children either die before maturity or get far into the tertiary stage before they are old enough to marry. One would think that this subject could be definitely settled with such a mass of cases constantly presenting themselves, but the difficulty is to ascertain all the facts, particularly in cases occurring in families of good social position. Men and women both will deny little peccadillos that would throw much light on the subject.

As regards the mortality of syphilitic children, it is given as fully thirty-five per cent. Abortion, the result of the death of the fœtus, takes place before the seventh month, as the result of infection of the mother during pregnancy between the first and seventh months. The fœtus thrown off has a livid, purple color; the skin shows nothing characteristic, but is easily detatched. The viscera show syphilitic lesions.

As regards the frequency of abortion, we quote the following from Dr. H. C. Jessen's monograph on "Hereditary Syphilis:"

"For the most careful analysis hitherto made of the fate of the offspring of syphilitic marriages, with reference to the frequency of abortion, the number of viable children, etc., we have again to thank Kassowitz. His statistics include 330 births occurring in 119 marriages under the influence of syphilis of the father, the mother or of both parents.

"Of these 330 children, 127, or 67 per cent., were born prematurely, and of these 127 births 31 were abortions, properly so-called. Again, of

these 127 births, 80 per cent. occurred when the mother and 32 per cent. when the father alone was syphilitic. Further, of these 127 children 102 were still-born; 11 died in the course of the first day; 7 in the course of the first week; 4 before the end of the first month, and but three survived.

"Of these 330 children, only 203 were carried to full term; of these again 9 were still-born, so that of 330 children of syphilitic parents 111, or about every third child, was still-born. Of the remaining 219, 80 died within six months, so that only 139 lived beyond childhood. If we now assume that all of these premature deaths were due to syphilis,which is not quite justified, then of 330 children only 191, or about 58 per cent., are carried off from the parental infection.

"These statistics, which are not from a hospital, but from the private practice of a single observer in the lapse of ten years, may give us some idea of the enormous number of children which are sacrificed every year to hereditary syphilis."

It is usually stated that the syphilitic child born at full term is thin and wrinkled. This is not always true. As a rule they appear well nourished and perfectly healthy, but before many days or weeks evidences of disease show themselves. The severity of the malady is in proportion to its activity in either or each parent at the time of conception. The time of its appearance after the birth, seems to depend upon its severity. Its early appearance indicates a very malignant type.

The prognosis is always grave in children born with manifestations of the disease, such as pemphigus or large bullæ scattered over the body, filled with serum and blood. The longer, however, the syphilitic dyscrasia is in making its appearance, the more favorable the prognosis.

Among the first indications seen in a child born apparently healthy are (about the sixth week) loss of appetite—the baby nurses badly, has restless sleep, its bowels are more or less disturbed and it has the snuffles. There is a difference of opinion as regards this snuffling, some attributing it simply to a congested condition of the nose with affection of the mucous membrane, and others to disease of the nasal bones. Some authorities go so far as to say that it is never present as a syphilitic manifestation unless the bones are implicated. The discharge may be offensive or crusts may form, seriously impeding the respiration of the child.

Emaciation commences as a result of the loss of the appetite and is usually progressive until the child is a mere skeleton, but in exceptional cases the diminution in weight is not noticeable. The skin of the face becomes discolored and is drawn tight over the bones. The eyes become very prominent—seldom sunken. The voice becomes hoarse, feeble and moaning from the implication of the larynx. The breathing is accompanied by a slight rattling and is performed through the mouth. Mucous tubercles soon make their appearance about the

anus and in a short time on the genital organs and in the folds of the skin, irritated by the urine and feces. On examining the chest and abdomen roseola will usually be found, after the sixth week, either preceding or accompanying the coryza. The early change of color from a bright red to a coppery hue is an important diagnostic feature. In place of roseola we may find small and large flat papules, at first dull red and afterward coppery, scattered over the body, similar to the same affection in adults. The pustular syphilide appears about the eighth week and is found more abundant on the thighs, buttocks and face, although invading the entire body. It is sometimes associated with the vesicular syphilide.

Pemphigus is sometimes seen at birth, but more often when the child is from one to six weeks old, and is situated mainly on the palms of the hands and soles of the feet. Gummata and gummatous ulcers may appear as early as the third year, but generally not until the tenth or twelfth. The viscera are affected at varying periods, from a few months to several years, the liver almost uniformly being the organ first implicated. Affections of the osseous, fibrous and cellular tissues are usually late in making their appearance, but exceptionally are very early. The temporary teeth are cut unusually early, are of a very bad color and soon crumble away. The child may possibly survive under good treatment until second dentition when the teeth, especially the upper central incisors, present certain characteristics, diagnostic of hereditary syphilis, and first described by Mr. Jonathan Hutchinson. The upper central incisors when first cut are unusually short, narrow from side to side at their edges and very thin. After a time a crescentic portion from their edge breaks away, leaving a broad, shallow, vertical notch, which is prominent for some years. The two teeth often converge and sometimes they stand widely apart. When this notching is not present or but slightly marked, there is still a dirty brownish color of the teeth and a narrow squareness of form.

Keratitis is seen in children of from five to fifteen years of age. The opacity commences in the center of the cornea and gradually increases until the greater part of the cornea is involved, giving to the whole structure the appearance of ground glass. It is followed by vascularization, not confined to the surface, but invading the whole thickness of the cornea, without any tendency to ulceration. Both eyes are usually affected, first one and then the other.

The treatment of hereditary syphilis varies according to the symptoms present in any given case. *Nitric acid* we have found one of the best remedies, particularly for ulceration of the uvula, pharynx and fauces; vesicles on the tongue and inside of the cheeks; swelling and phimosis of the prepuce; old ulcers on the body. All cases where much mercury has been taken by the parents. Ulcerations of mucous mem-

branes; affections of the periosteum and bones; hemorrhages; yellowness of the skin with constipation; oppressed breathing.

Arsen.—For pemphigus, ulcerations, suppurations; great exhaustion; marasmus; skin dry, shriveled; coldness and chiliness of the body; eruptions discharging a thin, acrid, burning ichor; excoriating discharge from the nose; restless sleep; cold, clammy sweats; black vesicles, or black eruption; complexion white and pasty-looking; pulse weak and fluttering; catarrh threatening suffocation at night.

Aurum—Disease of the nasal or cranial bones, with ozæna; scrofulous children; eyes prominent; redness of the sclerotica; swelling of the parotid gland; swelling of the testicles; roseola.

Asaf.—Caries and ozæna. Child cries when dressing the sores, or even when preparing dressings; irritable; distention of the stomach and bowels; colicky pains; stools brown and offensive; swelling of the female genitals; coldness of the hands with blue nails, and heat of the face.

Calc. carb.—Thin, pale face, with dark circles around the eyes; whitish stools; great debility; painless glandular swellings; offensive smell from the teeth; swelling of the tonsils; milk does not agree; sour vomiting; very frequent urination; unhealthy ulcerating skin; profuse sweat of the head.

Carbo. veg.—Child peevish, restless; skin blue and cold; urine dark and red with red sediment; hoarse, rough voice; oozing from the anus at night of a musty mucous; bleeding of the gums and nose.

Hepar. — Suppuration of indurated glands; pustular eruptions; ulceration of the throat; fetid breath; voice hoarse and husky; falling out of the hair; scurvy eruptions; burning urine, excoriating the parts; iritis; soreness and moisture in the fold between the scrotum and thigh, and about the anus; agglutination of the eyes at night; the nasal mucus is bloody.

Staph.—Caries of the teeth; ostitis and periostitis; restless sleep; very nervous, starting at the least noise.

Merc.—Affections of the mucous membrane, the skin and the glandular structures; greenish stools; turbid urine; loss of appetite; pale, bloated or sallow face; emaciation; nose pointed; breath offensive; the gums recede from the teeth; keratitis; copper-colored eruptions on the body.

Cinnabaris.—When mercury, although indicated, seems to be of no benefit. Ulcers with hard, raised, indolent edges; ulceration about the anus; swollen glands.

Fluoric acid.—Softening, swelling and curvature of the bones; painful ulcers in the mouth; offensive urine; sour, offensive perspiration.

Benzoic acid.—Copious, watery, but very fetid diarrhœa; stools watery, white; urine deep red, and very offensive; copper-colored eruption on the fingers; copious perspiration at night.

China.—Excessive weakness; one eye open and the other closed during sleep.

Tartar emetic.—Pustular eruptions on the thighs and scrotum; swelling of the inguinal or cervical glands; slimy, watery, yellowish stools; rattling breathing; ulceration of the mouth and tongue.

Argent. nitras, *Sepia*, *Silic.*, *Phos.*, *Phos. ac.*, *Kali. jod.*, *Kali. hyd.*, *Sulph.*, *Lach.*, *Lyc.*, *Thuja* and other remedies may be called for, and have proved valuable. The symptoms should be carefully studied in every case, as it is only by the most skillful treatment that hereditary syphilis can be cured.

Gonorrhœa and Gleet

GONORRHŒA.

Various names have been applied to this disease of the mucous membranes of the genital organs and eye, at different times and places. The American and English writers uniformly use the term, gonorrhœa; the French, the words, blenorrhagia, or "*chaude-pisse*," the latter being the popular name for clap.

The disease is a very ancient one, and numerous references to it can be found in the Bible. See Leviticus, xv, 2–13. It is also, by far, the most frequent affection originating in sexual intercourse, and is much more common in males than females. The causes are intercourse with persons similarly affected, or with one suffering from leucorrhœa, menstrual or acrid discharges. However, the affection is usually due to contagion, for married men, whose wives suffer from leucorrhœa discharges are rarely afflicted with urethritis.

Among the causes of urethritis are mentioned masturbation, the use of bougies, stricture, prolonged excitement of the genitals, fermented liquors, internal use of cantharis or turpentine, cancer of the womb, vegetations in the urethra, ascarides in the rectum, acrid urine, and cold.

Urethral gonorrhœa in males is a violent inflammation of the mucous membrane of the urethra, accompanied by a muco-purulent discharge, is usually produced by the contact of a specific virus, and is by far the most frequent affection arising from sexual indulgence. The word gonorrhœa, we should have stated, literally means a flow of sperm; the disease was so named because the older writers considered the discharge a flux of semen. Of the nature of the specific virus which gives rise to this affection, but little is known. It is true that the gonococcus has sometimes been found, in the early stages, in the discharge, but it by no means follows that this microbe is the cause of the disease. In women it is exceedingly difficult to find. The discharge containing it does not differ, chemically or microscopically, from mucous discharges occurring in other situations. It has been definitely ascertained, however, that the virus is not identical, but is distinct from that of syphilis, and that it does not affect any other tissue except the mucous. The specific poison is found usually in a purulent discharge from the urethra, although the mucous membrane of the anus, mouth, eye or nose may furnish the same specific discharge if inoculated with the poison.

Men are more liable to contract gonorrhœa than women, and the

parts usually affected are the urethra, inner surface of the prepuce, and the head of the penis; in the female, the urethra is not often affected, the disease being confined to the vagina, mucous membrane of the vulva and uterus.

The disease manifests itself, without any period of incubation, from two to eight days after an impure connection; that is, the symptoms are not well marked before the second to eighth day, although the poison probably acts immediately upon the affected tissue. In rare cases, the disease is developed in a few hours; in others, again, the affection does not make its appearance for fourteen days. Males with a large orifice of the urethra, and those with a long, narrow prepuce, are most subject to the disease.

The symptoms make their appearance in the following order: the first being a slight titillation along the course of the urethra and at the end of the penis, increased considerably by an erection. This symptom is usually, not always, accompanied by a feeling of weight in the penis. The seat of the disease is at first limited to the anterior portion of the urethra, but soon extends to the bulbous and membranous parts. Upon examining the penis, the orifice is found to be red, swollen, and stuck together by a thin, whitish secretion; if the penis is pressed between the thumb and finger, a small quantity of watery mucus oozes out; there is not much scalding or burning in urinating at this time—a slight smarting being felt only in the anterior portion of the canal during micturition. The foregoing are the usual symptoms of the first stage, which continues from two to four days.

In a short time, say a week or less, the discharge becomes abundant, thick like cream, and of a bright yellow or green color, staining the linen; or in some cases the discharge is mixed with blood, or consists of pure blood, due to the rupture of some minute blood vessel. A slight hemorrhage is sometimes a benefit rather than a detriment, as it relieves the congestion of the swollen parts. The glans penis now becomes hot, red, swollen, tender and painful, and the prepuce enlarged and œdematous.

General febrile disturbance is often well marked in first attacks, but not in subsequent attacks. The pain in voiding urine is now very severe, and extends the whole length of the canal, the patient feeling during the passage of urine as if he could bite a nail in two. The stream is apt to be forked or twisted. Erections occur almost nightly, often several times a night, producing excessive pain and hindering sleep. Chordee is the term applied to this form of erection, the penis being bent in the form of an arc with its concavity downward.

In many cases, in addition to these symptoms, there are tensive and drawing pains in the spermatic cords, testicles, perinæum, and groins. The disease is now at its height, and from this time on the symptoms

become less severe; the inflammatory or second stage is over, the erections occur but seldom, and the burning during micturition is slight. The duration of this stage varies from seven to twenty days, according to the habits and surroundings of the patient.

The disease rapidly subsides, leaving a whitish, viscid, stringy discharge, which gradually disappears, or remains for a long time, when it is called gleet. The duration of this, the last stage, is apt to be greatly prolonged when not influenced by the proper medicine. Relapses or aggravations from the neglect of hygienic and other laws of health are quite frequent. Everything which tends to irritate the urethra or genital organs should be strictly prohibited.

A discharge similar to gonorrhœa in its nature is sometimes occasioned by leucorrhœa, or by the menstrual flow, by excessive sexual intercourse, by the exposure of the parts to a cold wind, by want of cleanliness, and by the use of new wine, stimulants or unfermented beer. It is not easy to distinguish this form of gonorrhœa from the Simon-pure article when there are no other complications present, except that the symptoms are, as a rule, very much milder. The persons most liable to suffer from this form are those of a rheumatic or scrofulous diathesis, or those who have become weakened through any cause. We meet with many cases which have received no treatment whatever, and the duration seems to be indefinite.

In regard to the pathology of gonorrhœa, it is only necessary to state that it is an inflammation of the mucous tissue of the urethra, commencing at a small spot in the anterior portion of the canal, extending backward its entire length, and forward involving the prepuce. The inflammation rarely involves the peri-urethral cellular tissue. This membrane presents the same appearance as inflammation of other mucous structures. It becomes red, the follicles are enlarged, there is hyper-secretion of mucus, becoming purulent and the membrane becomes thickened, diminishing the size of the canal and of the stream. As the inflammation subsides, the surface becomes marked with patchy redness and fine granulations resembling small warts. When the inflammatory action is unusually severe, there is an effusion of lymph or plastic matter into the spongy substance of the urethra, causing that painful affection known as chordee.

Should the peri-urethral tissue be invaded at any time, abscesses are liable to form, which may or may not communicate with the interior of the canal, but are apt to form ulceration of the mucous membrane from without inward and open internally. "The result is a communication which permits infiltrations of urine, and which may become the commencement of a urethral perforation."

Gonorrhœa may be complicated with balanitis, phimosis, paraphimosis, general inflammation of the penis, orchitis, prostatitis, nephritis,

cystitis, chancre, bubo, retention of urine, hæmorrhage, phlebitis of the penis, conjunctivitis, arthritis, or abscess of the urethra, prostate gland or perineum. Balanitis, or gonorrhœa spuria, is simply an inflammation of the head of the penis and prepuce, and it is usually a very insignificant affection, but occasionally gangrene results, giving rise to very odd deformities. We need not dwell upon phimosis and paraphimosis, having already considered these affections in a former lecture.

General inflammation of the penis is rare, and yields readily to treatment. It is characterized by an erysipelatous redness and tumefaction of the whole organ. *Rhus.* acts well in this complication: so also does *Aconite.*

Cystitis, or inflammation of the bladder, is due to the extension of the inflammation from the urethra to the bladder, and rarely occurs until the fourth week. As predisposing causes, may be mentioned the use of irritating injections, abuse of alcoholic stimulants and overwork. The diagnostic symptoms are the passage of a few drops of blood at the close of micturition, with vesical tenesmus, itching in the head of the penis and constipation.

It must be understood that the inflammation seldom if ever implicates more than the neck of the bladder.

Chancre, of course, is not caused by the gonorrhœal poison, but may exist at the same time. Bubo may also be present in connection with the chancre, or may follow the gonorrhœa. In the latter case, the bubo will be found usually on but one side, and below Poupart's ligament—the number of ganglions involved varying from one to four. Retention of urine is occasioned by spasm of the neck of the bladder, excited by inflammatory irritation of this structure. Hæmorrhage, I have already stated, is due to the rupture of some minute blood vessel of the urethra. It is of rare occurrence, and takes place only during a violent erection or prolonged sexual excitement.

Orchitis, or gonorrhœal epididymitis, as it is now termed, is usually the result of a repulsion of the gonorrhœal inflammation by exposure to cold, or by the use of powerful injections, as the nitrate of silver, sulphate of copper, etc. Very rarely indeed is it occasioned by the continuous extension of the inflammation to the epididymus. The left testicle is more frequently attacked than the right, although, in some instances the inflammation see-saws from one to the other. The epididymus proper is the part chiefly involved in the majority of cases. Next to this, the tunica vaginalis, and lastly the spermatic cord. But it is not unusual for the three parts to be affected at the same time. It is rare, however, for any one of the three to be implicated alone. We need not take the time to here give the symptoms of this inflammation, as they have already been considered by your professor of surgery; suffice it to say that the organ is at first swollen, tender to the touch, and on motion, the pain in-

creasing, in many cases, to that degree that sleep is impossible, and the weight of the bed-clothes unendurable. Febrile disturbance accompanies in the majority of cases, but in others the patient is able to attend to his business. The termination is usually favorable, but exceptionally abscesses form in the cellular tissue underlying the scrotum, or even in the testicle.

Phlebitis of the penis is a very rare and unusual complication. Abscesses of the urethra, perineum and prostate gland are also very rare; they are due generally to, or at least happen in persons affected with stricture of the urethra.

Prostatitis, occurring in connection with gonorrhœa, occurs after the second week, and is due to the extension of the inflammation to the substance of the prostate gland. Irritating injections, exposure to cold and wet, protracted exercise and the use of alcoholic stimulants are predisposing causes. The patient complains first of a sense of weight in the perinium, followed by frequent and urgent desire to urinate, the stream being small and requiring considerable straining to force it out. Scalding, if present, is felt in the deeper portion of the canal. Constipation, with frequent and ineffectual urging to evacuate the bowels, is often a well-marked symptom. On introducing the finger into the rectum, the prostate gland will be found to be enlarged and very sensitive to pressure. Prostatitis usually terminates in resolution, rarely in suppuration. Should suppuration occur, it is recognized by chilly sensations or a pronounced chill, followed by high fever. Complete retention of urine is not uncommon in bad cases. The abscess may break and empty into the urethra, the bladder or the rectum, according to its situation. The rectum usually receives the contents of the abscess, and the termination is eventually satisfactory.

Cowperitis, or inflammation of Cowper's glands, is an occasional complication. The symptoms are similar to those of prostatitis, with which it is frequently associated. There is pain, deep seated, in the perineum, and suppuration is by no means an unusual termination. A urinary fistula may be the result.

Arthritis, or gonorrhœal rheumatism, is by no means a frequent affection, occurring in less than one per cent. of all cases, and only in connection with urethral inflammation. The exciting causes are not known.

The knee joint is the part most frequently affected, although no joint seems to be exempt. Compared with ordinary rheumatism, we find that the pain is never as great, the fever much less, the sweating absent, and the disease is not inclined to shift from one joint to another. The duration seldom exceeds five or six weeks at the most, under proper Homœopathic treatment. In badly treated cases, the duration may be indefinite and anchylosis the result.

Gonorrhœal ophthalmia is a frequent complication and a serious one.

The virus is carried from the penis to the eye by the finger of the affected individual. The conjunctiva is the part usually affected, although the iris and cornea may be involved, as the vessels of the tissues of the eye are intimately connected. When the conjunctiva alone is affected, the discharge is muco-purulent.

Chordee, as we have already stated, is present to a greater or less degree in nearly every case of gonorrhœa, coming on specially at night, after getting warm in bed, and it does not as a rule disappear at the close of the inflammatory stage. It is always attended with some pain, but when the penis, during the erection, is bent back toward the perinæum, the suffering is intolerable. Hemorrhage from the urethra sometimes accompanies the erection.

Stricture of the urethra often follows gonorrhœa, in consequence of the use of very irritating injections. Such a result does not often follow proper Homœopathic treatment. I say this because I have never yet seen a case of stricture following gonorrhœa that was not directly or indirectly due to nitrate of silver or other powerful injections. The treatment of stricture, aside from remedial agents, will be considered by your professor of surgery.

Gonorrhœa in the female is much less common and far less troublesome as a rule than in males. The reason for this partial immunity of women is owing to the fact that their parts are more or less protected by the natural secretion of the numerous glands; and secondly, by the fact that men are, in most cases, compelled to abstain from sexual intercourse while suffering from the disease. Owing to the fact that their menstrual and other discharges are frequently poisonous to the male urethra,women may be said to more frequently communicate than receive gonorrhœa. If the attack comes on suddenly in the female, accompanied by heat, pain and burning along the course of the urethra, aggravated during urination, and accompanied by a discharge from the meatus, we may be pretty certain what the matter is, for no form of leucorrhœa is attended with a discharge from the urethra. But gonorrhœa of the female urethra is the rarest of affections, for the reason that during coition the urethra is not apt to come in contact with the penis—the vulva, vagina and uterus being the parts most exposed.* It is in such or chronic cases or in cases of infection of the vulva, vagina and uterus, where the previous history cannot be ascertained, that it is impossible to make the diagnosis positively; but that need not interfere with your promptly curing the case. Dr. Ashwell says: "It is the duty of the physician to cure the disease, but rarely to venture upon an exposition of its nature. If he can positively affirm that it is of simple origin, let him do so, if

*Eminent authorities believe that women sometimes contract serious gonorrhœal inflammation of the tubes and pelvic peritoneum without exhibiting other signs of the disease.

suspicion has been aroused; if not, it is better to avoid any distinct allusion to the matter."

My friend, Dr. Jessen, gives the following differential diagnosis: —"The history of the attack furnishes more important aid to its diagnosis. Gonorrhœa has a very short period of incubation, and, as a rule, its symptoms advance with a rapidity and acuteness which is rarely met with in catarrhal inflammations. Therefore, if the sexual organs suddenly become the seat of a burning pain, which is soon followed by an itching irritation, with painful desire to urinate, increased sexual appetite, swelling, and local pain, with blenorrhagia, where no local irritants have been applied, and there is no traumatism, there is good reason to believe that the case is gonorrhœal, and not leucorrhœal; for leucorrhœa, with which this affection is most likely to be confounded, develops slowly, or, so to speak, has a chronic stamp from its very beginning.

"Where the symptoms of a catarrhal leucorrhœa and of a gonorrhœal inflammation are pronounced, the experienced physician will be clear in his diagnosis, but when the inflammation is slight, and the discharge is mild in its character, he will have more trouble in differentiating them. This is especially true if the woman is interested in concealing the real nature of her disease.

"In utero-vaginal catarrh, the general symptoms are congestion, inflammation and exudation, just as in catarrhal inflammations that are located elsewhere. These symptoms are identical with those of gonorrhœa, but in the latter affection they are characterized by a more rapid course and a greater degree of intensity, by an especial proneness to involve the urethra, and also the inguinal glands.

"The principal features of catarrhal inflammation are hyperæmia, swelling and structural changes, as œdema, with increased formation of epithelial cells, mucus and pus. In severe gonorrhœa of the vagina, for example, there is a copious secretion of serum from the vaginal follicles, but there is no great soreness of the vagina itself. In the mucous stage there is considerable tenderness, which increases as the case passes into the purulent form. In both, the secretion, which, from having been whitish or yellowish and slimy, becomes creamy, greenish and purulent, with an acid reaction. This last symptom is important, because the secretions from inflamed mucous membrane in other parts of the body are always alkaline. In this stage the discharge has a peculiar, strong and offensive odor."

Urethral gonorrhœa, although rare by itself, is sometimes associated with vulvitis or vaginitis, in which case the itching and smarting of the urethra is seldom very troublesome. It never gives rise to cystitis, although the inflammation may extend as far as the neck of the bladder and then cause considerable pain on micturition.

We have already hinted that in women several portions of the genital organs are affected, so that we may find in addition to or independent of urethritis, vulvitis, vaginitis or metritis. Inflammation of the parts composing the vulva is less common than vaginitis, and when not occasioned by the gonorrhœal virus, may be due to uncleanliness, masturbation, frequent coitus, chancre, injuries of the parts and numerous other causes. Vulvitis is analagous to balanitis in the male. It is said that when the inflammation is limited to the clitoris it is a sign of masturbation, and that when it commences at the fourchette and base of the labia minora it indicates an attempt at rape or repeated coitus. We need not repeat that the diagnosis is difficult and must frequently be made by the process of exclusion.

The symptoms do not differ materially from those of inflammation of other mucous membranes, consisting at first of heat and itching, with a reddened, tumefied and moist surface. In a very few days the discharge increases, becoming muco-purulent and quite offensive. There is much sensitiveness to touch, and the inflamed parts are painful on motion. Whenever the urine comes in contact with the inflamed parts, there is severe burning pain, and even the discharge irritates and inflames the skin if allowed to remain in contact with it. Nymphomania, or at least increased sexual desire and very painful coitus, are attendant symptoms in the majority of cases. If the disease is not speedily relieved by treatment, ulceration of the parts is apt to occur, and in some instances, an abscess in the groin.

Vaginitis, acute or chronic, may be due to contagion, but there are numerous causes which may produce it, viz., sexual excesses, ascarides. or foreign bodies in the vagina, the use of pessaries, uncleanliness, masturbation, syphilitic or other eruptions, exposure to cold and moisture and the eruptive fevers. Gonorrhœa of the vagina is more common than that of the urethra, vulva or uterus, and it is less painful than when the vulva is affected. The main symptoms are, at first, dryness, redness and tumefaction, with increased heat and sensibility; some pain on motion; frequent desire to urinate, with some smarting; dull pain in the hypogastric region; acrid discharge, at first thin and transparent, later, offensive, purulent, of a yellowish or greenish color, and sometimes bloody. It is very prone to become chronic, although the acute symptoms yield to treatment in a very short time. Contraction of the vagina may follow, and may even be so great as to completely occlude the canal.

Gonorrhœa of the uterus is not uncommon, but is less frequent than that of the vagina or urethra. It is very rarely primary, but is usually owing to the extension of the vaginal inflammation. There is no pain of consequence, but usually some slight disturbance of digestion, general malaise and irregular menses. The discharge is alkaline, whitish and gelatinous, and irritates the vagina while passing through it.

The complications in women are not so numerous nor so severe as in men. Bubo, inflammation of the Fallopian tubes, ovaritis, chancres and vegetations are the main complications, but, with the exception of chancre, are quite rare. Bubo, except when due to chancre, is less frequent in women than in men suffering from gonorrhœa.

Prophylactic Treatment.—Whether the prophylactic treatment of this affection should be told to the general public or not, is a question. As the disease is usually the result of an impure connection, the parties should suffer for their misdemeanors. Still we give you the best means known of preventing the disease. The parts should be well anointed with oil before, and well washed after the connection. If these precautions are followed there is slight danger of infection.

In regard to the treatment after the disease is fully developed (and we may here say that it is often obstinate and rebellious to our best endeavors), the following general directions should be given to the patient: Take no more exercise than is absolutely necessary; keep in bed if possible; keep the parts clean by bathing them in warm water, and by placing pledgets of lint between the prepuce and head of the penis; if obliged to be on the feet much, suspend the parts in a suspensory bandage; avoid stimulants, coffee, acids and meats, living on rice, bread, barley water, gum water, weak tea, etc. Avoid all impure thoughts. As for the remedies to be employed, every author and physician has his own peculiar set. The symptoms should decide in this affection as in other diseases, if you can get hold of them, but many physicians always give the same remedy in the first stage of every case; for instance, Grauvogl recommends *Natr. sulph.;* Wahle, *Bryonia;* Jahr, *Sepia;* Bæhr, *Merc. sol.;* Kafka, *Sulph.;* Berjeau, *Acon.;* and many others *Cannabis.* It is seldom, however, that we see cases in the first stage, as many persons imagine that while they have gonorrhœa they can contract no other disease, and thus let it run. They are also acquainted with the fact that often the disease subsides without treatment.

If we see a patient in the onset of the disease, we administer *Aconite,* which is often sufficient to cure the affection. The patient complains of burning in urethra when urinating, dysuria, and sometimes a tenderness of the neck of the bladder. If this drug does not control the inflammation, we are obliged to resort to *Gels.*, or some other remedy. Almost every drug in the Materia Medica has been recommended for gonorrhœa, but, in speaking of the different remedies, we shall confine ourselves to those which have been found curative for a certain definite set of symptoms. We shall speak of them, not according to their real and comparative value, but alphabetically.

Agave Americana has been recommended for "excruciating, painful erections, chordee, strangury, drawing in the spermatic cords and testicles, extending to the thighs, so violent that he wishes to die."

Agnus castus is indicated in "old sinners" (when the inflammatory symptoms have subsided), who have no sexual desire or erections, especially if the discharge is yellow and purulent.

Ant. crud. Hempel mentions this remedy and says it should be used in tolerably large doses. The symptoms indicating it are: Burning when urinating, the urine being mixed with blood; "the urethra feels sore to the touch, knotty; the emission of urine may even be completely repressed."

Argentum nit., the great remedy, used as an injection in old school practice, may be successfully employed, homœopathically, for the following symptoms: Burning during urination, with a sensation as if the urethra were closed and sore inside, or swollen inside; the last few drops of the urine are not emitted; in addition, there is a cutting pain extending to the anus, and a discharge of pus excoriating the parts (male or female). It may also be used for swelling of the penis, chordee, or for enlargement and induration of the testicle in consequence of suppressed gonorrhœa.

Berjeau recommends *Arsenicum* in gonorrhœa of the female, "when there is smarting, gnawing discharge, causing soreness of the parts with which it comes in contact; when standing, the discharge drops down, accompanied with emission of flatulence; or when there is also great redness of the parts." In the male, it has been successfully employed for tearing deep in the urethra.

Aurum is also recommended by the same author "for profuse discharge which excoriates the perineum and the inner parts of the thigh, with vesicular eruptions on these parts, or when labor-like pains are present. This remedy will be found useful also where there is inability to retain the urine, or for stricture of the urethra, with continual urging to urinate.

Byronia is another useful remedy in gonorrhœa of the male or female, when the discharge, which had almost ceased, increases again. Valuable when the labia are greatly swollen.

In regard to the curative power of *Cannabis* in this affection, there has been considerable dispute. Some assert that it is almost a specific. The remedy is certainly of service when the symptoms indicate it; when they do not, it is about as valuable as most of the new remedies which have been declared specifics in gonorrhœa. It is indicated in the inflammatory stage, when the urethra feels as if drawn up into knots; when the prepuce is greatly swollen and sensitive to the touch; when there is constant urging, with difficult urination; when there is dark redness of the glans and prepuce; and when chordee is a prominent symptom. Hempel recommends it for the symptoms which frequently accompany gonorrhœa, as rush of blood to the head, frontal headache, etc., but his doses are hardly what could be called homœopathic. He advises the

practitioner to give as high as fifteen to twenty drops of the strong tincture for a dose. If *Cannabis* is the indicated remedy, the 30th or 200th will act better than the strong tincture. This remedy is also of service in gonorrhœa of the female, "when there is cutting between the labia during micturition, the orifice of the urethra also being closed with pus, there being violent sexual desire, with swelling of the vagina."

Cantharis is sometimes called for when the inflammation extends to the bladder, with tenesmus; constant desire to urinate, passing but a few drops at a time, often mixed with blood; great difficulty in urinating, with intense pain; the discharge is yellow or bloody; excessive sexual desire, with erections at night. In the female, it is indicated for swelling of the neck of the womb, for pains in the kidneys and copious debilitating discharges, especially if the symptoms are accompanied with constant desire to urinate.

Some authors advise *Capsicum* for intense burning in the urethra, with white, cream-like discharge; and others for thick, purulent, yellow discharge, accompanied with pricking, burning, cutting pains in the urethra.

Cocculus is occasionally of benefit, especially "when there is tensive, aching pain in the orifice of the urethra when not urinating."

Copaiba, Berjeau says, is indicated "for a violet smell of the urine, or when the discharge is accompanied by a cutaneous eruption like measles or nettle rash, attended with great itching." It is also useful for yellow, purulent discharges from the urethra, and for bloody urine, with constant desire to urinate.

Berjeau also recommends *Cubebæ* for the same violet odor of the urine, especially when the discharge is dark and reddish. It is useful for retention of the urine also.

Calc. carb. is a useful remedy in gonorrhœa of the female, when the discharge is burning or milky; also in gleet, especially in fat, lymphatic persons. The general symptoms are well marked when this remedy is called for. *Cham.*, likewise, may be used in gonorrhœa of the female when the discharge from the vagina is yellow, acrid, smarting or watery.

Carbo. veg., if the gonorrhœal discharge is very offensive, will prove curative.

Conium we have used when the testicles were indurated, especially if the patient had been the subject of frequent nocturnal emissions.

Hempel advises *Dulc.* for gonorrhœa from suppressed tetter.

Hydrastis has been used as an injection with more or less relief of the smarting during urination.

Hepar sulphuris has been found of service in scrofulous persons when the discharge is white, yellow or fetid.

Kali. nit. is used by the French and other physicians for frequent urging to urinate, with burning during and after urination.

In gonorrhœa of the female, *Kreas.* is of service if the discharge is bloody, acrid or yellowish, and of a foul odor, especially when accompanied with smarting in the external parts.

Medor, suppressed gonorrhœa, or discharge thin, transparent, mixed with opaque, whitish mucus staining the linen yellow. It is likewise indicated for profuse, yellow, purulent discharge, most copious in the morning. Also for gleet of long standing.

Merc. should always be used when gonorrhœa is complicated with chancre or phimosis, unless the remedy has already been used to excess, when *Nit. ac.* would be better adapted to the case. It is also indicated when the discharge is yellowish, green or purulent, aggravated at night. When the gonorrhœa is not complicated with chancre, we prefer *Merc. cor.*, but when there is a chancre we use *Merc. sol.* to the best of advantage. Berjeau also recommends this remedy "when the orifice of the urethra is inflamed, and the forepart swollen with suppuration between the glans and prepuce, the glands being red, hot and painful when touched, accompanied with burning pain and itching, stinging and throbbing in the urethra, the urine passing with a feeble stream." In the female it will prove serviceable if the vaginia is swollen and inflamed, with a sensation of rawness or excoriation, the discharge being acrid or greenish and purulent.

Dr. Raue recommends *Mezereum* for hæmaturia during gonorrhœa. The discharge is thin and watery, greatly increased by exercise, and the urethra is very painful to the touch.

Millefolium has been used when the discharge consists of blood and watery slime, with swelling of the penis.

Nat. mur. is the best remedy to administer after the patient has used injections of nitrate of silver. Cutting in urethra after urination; thin, watery discharge.

Nit. ac. will be found of benefit in cases which have been badly treated with *Merc.*, especially when accompanied with chancres or balanitis. Some authors have recommended this remedy also for condylomata. *Nit. ac.* is just as useful in gonorrhœa of the female as of the male. Hemorrhage from the penis, scanty or profuse, is also a good indication for its administration.

Nux vom. is an excellent remedy when the patient has been treated allopathically with copaiba, cubebs, and other hot stuffs. The symptoms indicating it are constipation, hæmorrhoids, "pressive pains occurring at the orifice of the urethra when not urinating, accompanied with shuddering," and sharp, cutting pains near the orifice of the urethra, with more or less dull pain in the back of the head. In the female, it is indicated for swelling of the vagina, which is very sensitive to the touch; for "gnawing, itching eruptions on the genitals; for painless discharge of

yellow mucus or fetid mucus, with burning in the parts, and violent sexual desire."

Petroselinum may be used for tickling and itching in the urethra, especially near the root of the penis, with constant desire to urinate. The discharge is milky or yellowish.

Phosphorus is of service in the female when there is decided aversion to an embrace, especially if the discharge is milky. Tall, slim women.

Pulsatilla should be thought of in mild, timid persons, when the discharge is very abundant, no matter what the color; also in suppressed gonorrhœa, with swelling of the testicles. It is also useful in gonorrhœa of the female, when there is considerable pain in the uterus, vagina and labia.

Sulphur is important as an intercurrent remedy in persons of a scrofulous diathesis. In some cases it is sufficient to complete the cure, especially when there is considerable burning at the orifice of the urethra, accompanied by constant desire to urinate, the stream being smaller than usual. In the female the same general considerations indicate it, and in addition, "itching of the clitoris and burning of the exterior parts, accompanied with vesication, attended with a smarting, burning thin discharge, especially in the morning."

Thuja would be indicated if fig-warts were present, but, as we have already stated, they are generally an accompaniment of secondary or tertiary syphilis, and not of gonorrhœa. We might mention fifty other remedies which have been recommended in this disease, but enough has been said already in regard to the treatment, which is, at best, often unsatisfactory.

It has been stated time and again that the high potencies are powerless in the treatment of gonorrhœa and syphilis. This is a great mistake, and the cases now under treatment at the hospital, prove the truth of the assertion, that the properly selected remedy will cure in the 30th and 200th attenuation, or in fact in any potency.

GLEET.

Gleet or chronic urethritis, or, as it is sometimes called, blenorrhœa, is the most frequent, the most annoying and the most persistent sequel of gonorrhœa, which it follows, usually, without interval, or at most with an interval of but a few weeks. It is a disease generally devoid of pain and other signs of acute inflammation, and is always accompanied by a chronic discharge from the urethra.

The chronic inflammation is usually limited to a small portion of the mucous membrane, or may be located at several points, where it remains indolent for an indefinite length of time, or until it is aroused by some exciting cause. The accompanying discharge, invariably scanty, is not constant as in gonorrhœa, and consists of a blue, thick, mucoid material, more or less purulent and creamy. It is somewhat increased by alcoholic drinks, active exercise and fatiguing occupations. It sometimes disappears spontaneously for a few days at a time, and then returns without appreciable cause.

At times the urine contains long shreds, looking like vermicelli, even when the discharge is not particularly noticeable, or is unseen by the patient. On rising from bed in the morning, the afflicted one finds the lips of the meatus stuck together, occasioned by the drying up of the gluey discharge, forming a sort of scab over the meatus; or he perceives especially on deep pressure of the uretha, a single drop of transparent matter—neither of these conditions being attended by pain of any consequence on micturition. This characteristic drop is entirely absent during the day.

Gleety discharges may be present from other causes aside from a past attack of gonorrhœa, such as stricture of the urethra, prostatitis, ascarides of the rectum, masturbation and other troubles of the sexual and excretory organs. In children, it is sometimes seen during dentition, and in adults from want of cleanliness, from excess of coitus, from excess in alcoholic drinks and other causes. This form of gleet, however, is not contagious, whereas that following gonorrhœa is decidedly so. The symptoms of the two forms are identical.

In general terms, it may be stated that when the discharge is more or less purulent, it is contagious; but when blue, mucoid and sticky,

without stain, it is usually not so. It should be remembered, however, that any excess in eating or drinking, or sexual excitement, may aggravate the existing discharge, and convert what had become a non-contagious into a contagious gleet, the thin, bluish discharge becoming a purulent one. This aggravation lasts but a few days, usually, if the exciting causes are removed.

In all cases of gleet which are examined with the bougie, one or more tender spots will be found which usually bleed slightly. This tenderness is often due to a slight stricture already present, or is dependent upon inflammation of the deeper portions of the canal or of the prostate. It is estimated that at least eight cases in ten are dependent on stricture or to a granular and thickened condition of the urethra, the incipient stage of stricture.

As regards the pathological changes met with in gleet, it is sufficient to state that they are similar to those met with in chronic inflammation of other mucous surfaces. We need not dwell upon them in this connection.

The point which interests us most as practitioners is what will cure this aggravating and obstinate disease. Our old school friends use tonics, alteratives, astringent injections, bougies, etc., etc., and still the percentage of cures is very small indeed. Cases hang on for months and years in spite of the treatment. The majority of physicians believe that urethral discharge is not invariably accompanied by stricture, while a limited number contend that the presence of gleet always means stricture, and that by removing this a cure will certainly follow.

That the removal or cure of a stricture often dissipates a gleet no one will deny, but that it invariably does so, no one of any experience will for a moment consent to. We have in our limited experience, seen a number of failures where there was no longer any sign of the stricture. It is well known that gleet sometimes resists all sorts of treatment, and then suddenly disappears of its own accord, after the patient has "thrown physic to the dogs," and ceased to do anything.

Can we do better with our small pills? We are certain that we can if we follow Hahnemann's advice, and treat the patient and not the disease. When we treated gleet as such our efforts were *nil*, but since we have treated the patient, taking into account all of his symptoms, we have had better success.

The treatment should consist, first, of strict attention to the diet and habits of the patient, for the use of alcoholic drinks, salty things, asparagus and excessive sexual intercourse all tend to aggravate and prolong the disease. The patient should drink freely of water, in order to dilute the urine, and thus prevent irritation of the urethra by its salts. If stricture exists, this should receive attention.

As regards remedies, many might be mentioned, but we shall confine

ourself to those which have been found beneficial, remarking that *Sep.*, *Sil.* and *Sulph.* have proved the most useful. It will not be possible in this paper to give all the indications for each remedy, but only those symptoms which one is most apt to meet with; and it is only by carefully questioning the sufferer that you will learn that there is anything the matter aside from the gleety discharge.

Sepia we place first on the list. The characteristic indications for its use are a milky or yellowish discharge; urine dark and turbid, or offensive; copious perspiration of the genitals; fetid perspiration of the axillæ, pain in the small of the back, occipital headache, melancholy mood.

Sil.—Thin, fetid discharge; urine yellow or light-colored; night sweats; fetid sweat of the feet; chilliness; chronic constipation; scrofulous, broken-down persons; constant feeling of chilliness, even while taking exercise.

Sulph.—Discharge whitish, mucous; urine covered with a greasy pellicle; coldness of the feet, and pain in the top of the head; weak, faint spells occurring frequently through the day. It follows well after *Sepia* has ceased to benefit the patient.

Cannab.—Discharge thin and watery, of disagreeable smell; urine is voided in a spray; urine mixed with filaments or blood; feeling as of a weight on the vertex; sleepiness during the day and sleeplessness at night.

Caps.—Discharge muco-purulent; cold and shriveled testicles; patient is taciturn and obstinate; is very sensitive to the open air.

Ferr.—Discharge is mucous; face fiery-red at times, and at others earthy and pale; puffiness of the face around the eyes; paleness of the mucous membranes.

Kali-bi.—Discharge stringy, jelly-like; escape of prostatic fluid during stool; high colored urine with pain across the back; complete indifference as regards his disease.

Nit-ac.—Discharge occasionally bloody; after the abuse of mercury; urine smells like that of horses; fig-warts; patient is irritable and vindictive; herpes-like eruption about the genitals.

Nux vom.—After allopathic drugging, or for aggravation of the disease after alcoholic stimulants or other excesses; valuable in hemorrhoidal subjects. Hypochondriac patients, or those who want to talk about their condition; bowels constipated, as a rule.

Graph.—Discharge gluey; urine turbid; patient sad and despondent; anæmic, constipated; tending to ulcerations of the skin.

Nat-mur.—Discharge thin and watery; after injections of nitrate of silver; craves salty things, although the use aggravates the trouble; aching in the testicles; the patient is very anxious about the result of the long continuance of the disease.

Petro.—Gleet of old people; slight burning in the navicular fossa while urinating; discharge milky; voluptuous itching of the genitals.

Agnus.—Discharge yellow, purulent; impotence; discharge of prostatic fluid while bearing down at stool; excoriations about the anus and genital organs.

Phos.—Discharge watery; profuse, strong-smelling urine, sometimes with greasy pellicle; tall, thin persons with black hair; pale, sickly persons; weakness of the memory; tendency to cough, and painless, watery diarrhœa from the least exposure.

Puls.—Discharge smells badly; urine discharged in a thin stream; mild, gentle persons predisposed to catarrh, diarrhœa, etc. Smoking seems to aggravate the disease, and so also does the use of rich food.

Thuja.—Copious, watery discharge; fig warts; sweet, honey-smelling sweat on the genitals; the patient experiences the feeling of a liquid passing along the urethra, drop by drop; continued dropping of the urine after micturition.

This list might be indefinitely extended. Consult also remedies mentioned for gonorrhœa.

REPERTORY.

GONORRHŒA OR GLEET OF MEN.

URETHRA, aching in—Bry., Canth.
aching after micturition—Puls.
aching at the orifice—Canth., Nux-vom.
aching, with pressure—Cannab.
agreeable sensation in, during micturition—Gels.
agglutination of orifice—Calc., Cannab., Natr-m., Petros.
biting pains in the fore part—Cannab., Copaib., Merc.

URETHRA, biting pains during micturition—Ars., Canth., Cham., Graph., Merc. sol., Natr.-m.
biting pains after micturition—Copaib.
biting pains when not urinating—Berb.; Cannab.
burning pains—Bry., Canth., Con., Thuj.
burning pains morning after erection—Natr.-m.
burning pains morning during micturition—Flu-ac., Seneg.
burning pains morning after micturition—Con., Flu-ac., Thuj.
burning pains forenoon after micturition—Lyc.
burning pains forenoon during micturition—Lyc.
burning pains afternoon during micturition—Hell., Natr-c., Thuj.
burning pains evening—Natr-c., Petr., Phos., Sulph.
burning pains evening during micturition—Seneg.
burning pains evening after micturition—Sep.
burning pains night—Canth., Sulph.
burning pains night after micturition—Thuj.
burning, before micturition—Bry., Cannab., Merc.
burning at commencment of urination—Cannab., Merc.
burning during micturition—Ac., Agar., Agnus., Ant-c., Ant-t., Arg-nit., Ars., Aur., Bov., Calc., Cannab., Canth., Caps., Carbo-veg., Caust., Chin., Clem., Cocc., Colch., Con., Copaib., Cubeb., Hep., Lyc., Medor., Merc., Mezer., Millif., Natr-c., Natr-m., Natr-sul., Nit-ac.,

Nux-v., Petr., Petros., Sep., Sil., Staph., Sulph., Thuj.

URETHRA, burning, extending into bladder after urination—Lyc.
burning, at the orifice—Canth., Caps., Nit-ac., Puls., Sep., Thuj.
burning, with itching—Apis., Copaib.
burning, with soreness of prepuce—Chin.
burning, with stitches—Cannab.
burning, with stitches in fore part—Bry.
burning in middle of, when not urinating—Staph.
contraction of—Bry., Canth., Clem., Puls., Sulph.
crawling pains, extending backward—Camph., Nux.
crawling, after micturition—Canth.
crawling, when not urinating—Mezer.
crawling, in morning in bed—Petros.
crawling, when moving—Thuj.
cutting, morning during micturition—Graph., Merc.
cutting, evening before micturition—Bry., Calc., Canth., Phos-ac.
cutting, evening during micturition—Calc., Canth., Carbo-v., Con., Hep., Puls., Rhus.
cutting, at close of micturition—Natr-m., Sulph., Arg-nit.
cutting, after micturition—Calc., Canth., Natr-m., Sulph.
cutting, extending backward—Copaib.
cutting, when not urinating—Caps.
cutting, before and after stool—Sulph.
drawing, morning after micturition—Carbo-v., Natr-m.
drawing, when not urinating—Puls.
drawing, extending to anus—Phos-ac.
hemorrhage from—Arg-nit., Canth., Lyc., Merc., Nit-ac.
itching in fore part of—Aur., Canth., Cannab., Ign., Merc.
pinching, before urination—Natr-m.
pinching, when not urinating—Verat.
pinching, during urination—Arg-nit., Carbo-v.
sensation of dropping from, after micturition—Thuj.
sensation as if burning drops ran along, after micturition—Arg-n.
sensation of constant urging to urinate—Sulph.
soreness at the meatus—Copaib., Clem., Nux., Nit-ac.
soreness, internal, continuing after urination—Arg-nit., Medor., Nux.
stitches in—Acon., Apis., Arn., Aurum., Calc., Cannab., Canth., Cocc., Con., Ign., Merc., Sep., Sulph., Thuj.

stitches in, when not urinating—Bell., Caps., Cannab., Phos-ac.
stitches in, while walking—Ign.
stitches in meatus—Phos-ac.
stitches in, extending to abdomen—Merc.
stinging, when not urinating—Phos-ac., Thuj.
tearing in the fore part—Ant-t., Lyc., Thuj.
tearing, when not urinating—Ars., Bry., Ruta., Sulph.

URETHRA, tearing, extending to the perinæum—Mezer.
throbbing in—Copaib., Hep., Merc.
twitching pain in—Petr., Thuj.

INEFFECTUAL desire to urinate—Canth., Sarsap.

SPERMATIC CORD, pain in—Puls., Spong.

TESTICLES, pain—Arn., Aur., Clem., Con., Nux., Puls., Spong.

COWPER'S GLAND, itching and pressure—Petros.

GENITALS, coldness of—Gels., Lyc.
sweat of—Gels., Thuj.

DISCHARGE, acrid—Copaib., Creas., Sarsap.
albuminous—Petros.
bloody—Canth., Millefol., Nitr-ac., Puls.
green—Merc.
milky—Copaib., Lach., Petros.
mucous—Caps., Ferr., Medor.
offensive—Carbo., Puls., Silic.
of pus—Agnus., Bar., Caps., Copaib., Con., Natr-m., Medor.
thin—Medor., Natr-m., Phos-ac., Phos.
transparent—Medor., Mezer., Phos-ac.
watery and slimy—Cannab., Natr-m., Thuj., Fluor-ac.
yellowish—Agnus., Canth., Calc., Caps., Hep., Medor., Nit-ac., Sarsap., Thuj.
increases, after having decreased—Bry.

GONORRHŒA OF WOMEN.

URETHRITIS—Acon., Canth., Cannab., Gels., Thuj.
VULVITIS—Bell., Bry., Calc., Canth., Cannab., Carbo., Con., Creos., Lyc., Merc., Nit-ac., Sabin., Sep., Sulph., Thuj.
VAGINITIS—Acon., Bell., Cham., Calc., Canth., Creos., Nux, Nit-ac., Puls., Sabin., Sep., Sulph.
METRITIS—Acon., Ars., Bell., Bry., Canth., Carbo-v., Coloc., Con., Creos., Ign., Hep., Nit-ac., Phos., Plat., Puls., Sep., Sulph., Lach., Lyc., Merc., Nux.
DISCHARGE, acrid—Alum., Ars., Aurum., Cham., Creos., Ferr., Ign., Merc., Phos., Sabin., Sep., Sil., Sulph.
bloody—Chin., Cocc., Lyc., Nitr-ac., Sabina.
greenish—Cubeb., Merc., Natr-m., Puls., Sep.
milky—Calc., Creos., Gels., Lyc., Phos., Puls., Sep., Sil., Sulph.
mucous—Bell., Calc., Mez., Nitr-ac., Nux., Phos.
offensive—Creos., Nux., Nitr-ac., Sabin., Sep.
watery—Cham., Creos., Ferr., Graph., Merc., Sulph., Sep.
yellow—Ars., Cham., Creos., Merc., Nux, Stann., Sep., Sulph.
purulent—Ign., Merc., Sabin., Sep.
BEFORE URINATION, burning—Apis., Bry., Calc., Camph., Canth., Caps., Puls.
cutting—Bry., Camph., Canth.
cutting in abdomen—Nit-ac., Sulph.
colic—Puls.
contraction in urethra and rectum—Natr-m.
discharge of mucus—Creos.
impatience—Sulph.
pressing pain—Merc., Nux., Puls., Petr.
pressure in bladder—Arn.
pain in neck of bladder—Nux.
stinging—Nux.
DURING URINATION, anxiety—Cham.
abdominal pains—Bry., Lyc.

During Urination, burning—Apis., Arg-nit., Arn., Ars., Bell., Bry., Calc., Camph., Cannab., Canth., Caps., Caust., Cham., Chin., Con., Creos., Gel., Ign., Lyc., Merc., Mezer., Natr-c., Natr-m., Nit-ac., Nux, Petr., Phos., Puls., Sil., Stann., Staph., Sulph., Thuj.
burning in vulva—Creos.
biting in orifice—China.
biting—Ign., Mezer., Merc., Natr-m., Sep., Thuj.
constriction in left groin—Ars.
cutting—Calc., Canth., Con., Merc., Nit-ac., Puls., Staph., Thuj.
drawing—Con.
gnawing—Caust.
itching—Arg-nit., Cham., Petr., Sulph., Thuj.
nausea—Merc.
pinching about navel—Acon.
prickling—Caps.
pressure upon uterus—Con.
soreness—Calc., Cannab., Ign., Lyc., Mezer., Natr-c., Nit-ac., Phos., Sil.

At End of Urination, cutting pain in orifice of urethra—Arn., Canth.
dropping of blood—Cannab., Canth., Puls.

After Urination, burning—Apis., Camph., Cannab., Canth., Caps., Chin., Con., Lyc., Merc., Nit-ac., Puls., Thuj.
cutting—Arg-nit., Camph., Canth., Caps., Mezer., Staph., Sulph.
colic—Staph.
crawling—Canth., Lyc.
dribbling—Arg-nit., Natr-c., Petr., Sulph., Thuj.
discharge of mucus—Nit-ac.
feeling as if more were to come—Stann.
involuntary discharge—Sil.
passes drops of blood—Mezer., Sulph.
renewed desire—Calc., Nit-ac.
soreness—Nux.
stinging—Merc., Sulph.
stitches—Arn., Con.
tenesmus—Con., Sulph.
tickling—Canth.
weakness—Ars., Phos.

During Menses [Only those symptoms are given here which are covered by less than seven remedies.]
attacks of faintness in the morning—Nux.

During Menses, asthma—Chin.
agglutination of eyelids in morning—Calc.
bloatedness—Alum., Cocc., Natr-c.
bearing down—Bell., Thuj.
breathing difficult—Calc.
breasts, pain in—Con., Merc., Thuj.
burning in eyes—Nit-ac.
cramp in calves—Phos.
cold perspiration on forehead—Phos.
coughing up blood—Sep.
clonic spasms—Chin.
contraction in rectum—Cocc.
convulsions—Cocc., Puls.
coryza—Alum.
constipation—Apis.
colic—Aur., Chin., Natr-c.
chills—Bell., Creos., Natr-c.. Nux., Phos., Puls.
coldness of limbs—Cham.
general coldness—Thuj.
diarrhœa—Alum, Caust., Cham., Creos., Natr-c.
deglutition painful—Calc.
darkness before eyes—Chin., Sep.
dullness of teeth—Merc.
drowsiness—Sulph.
dryness and burning of tongue—Merc.
epistaxis—Sulph.
eruption—Apis., Con., Sil.
eructation—Nit-ac.
ears, rushing sound in—Creos.
ears, singing and roaring in—Petr.
face-ache—Natr-m.
face yellow—Caust.
face, swollen—Chin.
face, pale—Puls.
feet, swelling of—Calc., Lyc.
feet, heaviness of—Sulph.
feet, cold—Sil., Sulph.
foul taste—Sep.
foul odor from mouth—Sep.
flatus—Creos.
gums swollen—Merc., Nit-ac.
heat in head—Apis., Bell., Calc., Ign.
heat in hands and soles of feet—Petr.
hardness of hearing—Calc., Creos.

During Menses, itching of vulva—Lyc.
inclination to commit murder—Merc.
improvement of mental condition—Stann.
ineffectual straining at stool—Calc., Puls., Sulph.
lachrymation in morning—Calc.
obscured vision—Puls., Sep.
pain in ovary—Cham., Phos.
pain in right ovary—Apis.
pain in rectum—Apis.
pain in limbs—Bell., Bry., Calc.
perspiration of chest—Bell.
perspiration of chest and back—Creos.
prolapse of rectum—Aur.
pressure in epigastrium—Caps.
pressure in abdomen as from a stone—Cocc.
palpitation—Nit-ac., Sulph, Thuj.
restlessness of the legs—Thuj.
salty taste in the mouth—Merc.
stitches in rectum—Ars.
stitches in chest—Con., Puls.
stitches in side—Creos., Natr-c.
spasms of stomach—Puls.
sleeplessness—Sep.
soreness about vulva—Sil.
soreness of throat—Sulph.
toothache—Ars., Calc., Natr-m., Nit-ac., Phos.
thirst—Bell.
twitching of eyelids—Natr-m.
vomiting—Ign., Phos., Puls.
vertigo—Nux., Sulph.
weeping mood—Puls., Thuj.

COMPLICATIONS OF GONORRHŒA.

Abscess.—Apis., stinging pains; Asaf., dark red, hot; Bry., frequent thirst; Cham., pain of chronic; Hep., hastens suppuration; Lyc., worse at 4 P. M.; Petr., unhealthy skin, small wounds suppurate; Sil., prevents unsightly scars; Stram., violent pain, driving one mad.

Arthritis.—Apis., stinging pains; Arn., bruised feeling; Ars., restlessness, with relief from motion; Acon., high fever, thirst, anxiety; Bry., worse from motion; Benz. ac, scanty, dark brown, fetid urine; Calc., after Rhus; Kali-jod., great general debility; Led., pains run up, worse in warmth of bed; Lyc., old people, worse from 4 to 8 P. M.; Menzer., urine hot with red sediment; Nux., habitual drinkers; Puls., constant chilliness, diarrhœa, thirstlessness; Rhus, worse during rest, better from continued motion; Sars., shooting pains in head; Sil., acute pains remitting from time to time; Sulph, tearing pains from knee to crest of ilium, left side; Thuj., covered parts hot and dry, uncovered moist.

Balanitis.—Acon., itching in prepuce; Arn., injury; Bry., increased discharge after improvement; Calc., scrofulous persons; Cann., gets angry at trifles; Caps., constant pressure in glans; Chin, burning in glans and prepuce; Ign., nervous; Merc., purulent greenish secretion, worse at night; Mezer., fine pricking stitches in the glans; Nit-ac., discharge of bloody slime; Nux., secretion, copious, worse evenings; Phos-ac., gnawing pains; Puls., mild, gentle persons; Rhus, after getting wet; Sabin., violent erections; Sulph., icy coldness and swelling, with redness of glans; Thuj., violent stitches and soreness in the glans.

Bubo.—Ant-t., quarrelsome; Apis., great pain and sensibility; Ars., intense burning; Bapt., painless; after exposure to cold; Carbo-an., constipation, passing flatus only; Carbo-veg., great prostration; Graph., scrofulous women; Hep., suppurating;

Merc., very painful; Nit. ac., after abuse of mercury; Sil., scrofulous persons; Thuj., with fig warts; Zinc., left side.

Cowperitis.—Acon., from cold; Cinn., increased sexual desire; Hep., when suppuration threatens; Merc., desire to urinate after micturition; Sil., after suppuration; Thuj., much straining during urination.

Cystitis.—(See urinary complaints for indications) Acon., Apis., Arn., Ars., Bell., Calc., Cann., Canth., Caps., Carbo. veg., Caust., Coff., Coloc., Cupr., Dig., Dulc., Graph., Hell, Hep., Hyos., Lach., Lyc., Nit. ac., Nux., Phos. ac., Puls., Ruta., Sars., Sep., Sil., Sulph., Thuj.

Chordee.—Camph., acrid urine; Canth., bloody urine; Caps., urine increased; Iod., frequent and inveterate urethritis; Lupulin; Puls., mild persons; predisposed to catarrh or diarrhœa.

Eczema or Herpes.—Arn., from irritation or injury; Caust., rheumatic subjects; Dulc., bleeding; Hep., after mercury or ointments; Merc., voluptuous itching; Petr., constant oozing, itching; Phos. ac., itching creeping, moist; Sep., aggravated by scratching; Thuj., worse from cold water, better from warm.

Epididymitis (Orchitis).—Ant. t., nausea; Arg. n., bruised or contusive pains; Ars., cramp-like, cutting colic; Aur., aching, tensive pains; Bell., violent lancinations, worse P. M.; Brom., induration of left testicle; sensation of coldness; Cann., pulling or pressure in testicle; Caps., cramp-like pains in testicles; Chin., tearing pains in left testicle; Clem., swelling of right half of scrotum; pinching pains; Cos., from injuries; Cocc., spasmodic drawing pains; Ign., peculiar feeling of weakness in pit of stomach; Merc., tearing and shooting pains, shining redness of scrotum; Nit. ac., painful swelling of spermatic cord; Nux., suppressed gonorrhœa, ineffectual desire to urinate; Phos. ac., gnawing pains; Puls., suppressed gonorrhœa; pressive and tensive pains, right testicle; Rhod., testes intensely painful to the touch; contusive pains; Spong., chronic drawing pains; Staph., drawing, burning stitches in right spermatic cord; Sulph., when induration has commenced; persons with a dirty greasy skin; Thuj., aching pain, aggravated by walking.

General Inflammation of Penis.—Acon., with fever, thirst, etc.; Bell., with nervousness; Canth., urinary troubles; Rhus., erysipelatous redness.

HEMORRHAGE.—Acon., hot, dry skin, thirst; Arg. nit., with painful tensive erection; Canth., with sharp pains in back; Cinnab., scrofulous persons; Hep., urine blood red; Merc., moist tongue with great thirst; Nit. ac., discharge of bloody slime or pure blood; Sep., pain in small of back and region of kidneys; Sil., scrofulous persons, fetid smell of feet; Tereb., bloody urine.

HYDROCELE.—Ars., with tendency to general dropsy; Aur., melancholy persons; Calc., young scrofulous persons; Con., from injury; Dig., nausea, poor digestion; Dulc., after taking cold; Fluor. ac., suppression of stool and urine; Graph., persons subject to herpetic affections; Hell., of children; coolness of body; puffiness of legs; Merc., flesh soft and flabby, perspiration at night; Phos., in consumptives; Puls., persons subject to varicose veins; blue eyes, light hair; Rhus., left side only affected; Sil., ill-feed, ill-nourished persons; Spong., young scrofulous persons; Sulph., very large swelling, tense and shining.

NYMPHOMANIA.—Agar., selfishness; Ars., restlessness, thirst for cold water; Cannab., sterile women; Canth., aggravated urinary complaints; Carbo. veg., varicose veins in the vulva; Chin.,lying-in-women;Cimicif.,with acute mania; Cocc, chlorotic women; Coff., would like to rub the part, but it is too sensitive, ecstacy; Dig., very slow pulse; Dulc., sexual desire increased by a cool change in the weather; Hyos., desires to expose her person; Lach., worse after sleeping, sadness; Mosch., intolerable tickling in the genitials; Phos., pregnant women with spasms; Plat., in virgins, with soft, clay-like stools; Puls., mild, gentle women, with blue eyes; Sabin., music is intolerable; Sil., nausea during an embrace; Staph., thinks all the time about sexual things; very sensitive to the least impression; Stram., face bloated with blood; Thuj., fig warts; Verat., mania, with lewdness; Zinc., better during the menstrual flow.

OPHTHALMIA.—Acon., after exposure to cold winds; Ailan., cases inclined to become chronic; Ant-t., with nausea; Arg-nit., children; Ars., skin rough, dry and dirty looking; profuse purulent discharge; Merc., discharge thin; frequent relapses; Nit-ac., copious yellow discharge, worse at night; Puls., discharge profuse, thick, white or yellow; mild, gentle persons; Sulph., eruptions on the head and face; aversion to and aggrava-

tion from washing the eyes with water: scrofulous persons.

Ovaritis.—Acon., from cold or fright; Ant-c., with nausea and vomiting; Apis, stinging pains; Ars., intense burning pains; Aur., melancholy; Bell., right ovary, pains come suddenly; Bry., worse from motion; Canth., with dysuria; Chin., from frequent sexual intercourse; Coloc., colicky pains; Con., labor-like pains; Hep., when suppuration is feared; Ign., with weak, empty feeling in pit of stomach; Lyc., shooting pain from right to left ovary, worse at 4 P. M.; Nux, after drugging, stimulating drinks, etc.; Plat., with excessive sexual desire: Rhus, pain, better from motion; Thuj., left ovary worse from walking, riding, and during menses; Zinc., left ovary, better during menses.

Paraphimosis.—Acon., accidental; Cannab.; Cinnab., scrofulous persons; Coloc., tumefaction of the prepuce; Con., when due to contusions; Kali-jod., Merc. Nit-ac., after abuse of mercury; Rhus, rheumatic persons; puffy swelling; Sulph., when well indicated remedies do not act.

Phimosis.—Cannab., dark redness of prepuce; Caps., urethra painful to touch; dwindling of testes; Cinnab., penis swollen, jerking in the penis; Coloc., tumefaction of the prepuce; Con. and Arn., when due to contusions; Merc., in syphilitic persons; Rhus, puffy swelling of both prepuce and glans; worse from wet poultices; Sulph., scrofulous persons, when other well-chosen remedies fail.

Prostatitis.—Acon., High fever; Apis., incessant desire to urinate; Ars., chronic cases; debility; Bell., pain worse on right side; Bry., with constipation; Cannab., darting stitches in posterior part of urethra; Con., urine flows and stops; Cycl., pressing pain as from sub-cutaneous ulceration near the anus; Dig., pale urine, but scanty; motion increases the desire to urinate; Hep., when suppuration threatens; Kali-jod., lancinating and throbbing pains; Jod., testicles diminished in size; Lyc., stitches in neck of bladder and anus at the same time; Merc., continual desire to urinate, continuing after micturition; aching in perinæum; Phos., tall, slim persons with chronic constipation; Puls., great heat and pressure in perinæum; stools small and of flat shape; Sil.,

scrofulous, broken down persons; Sulph., pain of a burning character from prostate to end of penis; Spong., chronic enlargment; Thuj., sensation in the rectum as though a bladder had formed.

RETENTION OF URINE.—(See urinary complaints) Acon., Apis., Arn., Ars., Bell., Cann., Canth., Carbo., Con., Hell., Hyos., Lyc., Nux., Puls., Rhus., Sulph., Zinc.

STRICTURE SPASMODIC OR OTHERWISE.—Acon., with inflammatory fever; Agar., Arg-nit., pain in urethra as if swollen and closed; Bell., sudden lancinating pains; Berb., premature emission of semen; burning in left testis, epididymus, spermatic cord; Cann., obstinate, irresistable urging to urinate; Camph., strangury, acid urine passed drop by drop; Canth., passes but a few bloody drops at a time; Cic., following inflammations; Clem., urine passes slowly and in a thin stream; Con., urine flows and stops; Dig., pressing and burning in middle of urethra, as if too narrow; Jod., violent and continual erections; Kali-jod., excessive swelling of the glans penis; Medor, chronic stricture; Merc., with greenish discharge, worse at night; Nit-ac., after abuse of mercury; Natr-m., after abuse of nitrate of silver; Nux., painful, ineffectual desire to urinate; Op., constipation, hard, black balls; Sil., discharge of thin, watery matter; Stram., cadaverous smelling stools; Sulph., morning diarrhœa; suppressed gonorrhœa; Thuj., dropping of urine after micturition; the stream is frequently arrested.

VARICOCELE.—Acon., Arn. and Con., due to injuries; Bell., congestion in head or other parts of the body; Calc., increased sexual desire; Ham., Lyc., weakened sexual power; Lach., great depression of spirits, livid appearance of veins; Nux., constipation, gastric derangements; Puls., persons of a lymphatic temperament; Sep., heavy and tender feeling, chronic cases; Sulph., morning diarrhœa, scrofulous persons.

VEGETATIONS (Condylomata).—Nit-ac., Staph., Thuj.

DISEASES OF GENITAL ORGANS.

NOT NECESSARILY COMPLICATIONS OF GONORRHŒA.

IMPOTENCE.

(Incapacity for sexual power in men or women. Due to malformation of copulatory organs; to spermatorrhœa, varicocele, castration, masturbation and nervous influences.)

AGAR.—Entire relaxation of the penis; every attempt at coition is followed by great debility and languor, and sometimes by burning-itching of the skin.

AGNUS.—Great deficiency of sexual instinct, the penis being so relaxed that nothing excites it; discharge of prostatic fluid at stool; discharge of mucus from the urethra during sexual excitement.

BARYTA.—Numbness of the genitals; heaviness in small of back and loins; cloudy urine with yellow sediment.

CAMPH.—Coldness, weakness and atrophied condition of the genital organs.

CANTH.—Coldness of the penis and utter absence of erections, the result of previous excesses.

CAPS.—Cold and shriveled testicles, scrotum and spermatic cord; drawing pains in the cord.

CUPR-ACET.—Transient erections, with tension in the perinæum, and rheumatic pains in the back and legs.

GELS.—The result of masturbation; organs relaxed; absence of sexual feeling; mind depressed; constipation.

LYC.—Penis cold, blue, relaxed; loss of sexual desire; exhaustion; result of sexual excesses. In women, pain in back, right ovary; leucorrhœa.

Mosch.—With diabetes, or following a cold.

Nit-ac.—In syphilitic cases after the abuse of mercury.

Phos.—From conjugal onanism; weak memory; emaciation; tendency to cough; pulse unsteady and tremulous; anxiety.

Phos-ac.—Semen is discharged without erection; feeling of weakness of the genitals; debility and apathy.

Plumb.—Excessive emaciation and great debility; hectic fever.

Sulph.—From masturbation; ejaculation takes place as soon as he approaches his wife; icy coldness and swelling of the parts. Women who have lewd dreams, with discharge from the vagina.

ONANISM.

(Masturbation, self-abuse).

ANT-C.—Sadness; gastric derangements; alternating constipation and diarrhœa.

CALC-CARB.—Palpitation of heart; cough; vertigo; headache; constipation, with chalky stools; increased sexual desire at night. Women with too early and too profuse menses, acrid leucorrhœa, cold, damp feet.

CARBO-V.—The most innocent food disagrees; greenish, acrid leucorrhœa, irritable and ill-tempered.

CHIN.—Weakness; painless diarrhœa; aversion to society.

COCC.—Sadness; irascibility; anxiety; imaginary fears; frontal headache.

CREOS.—Chronic cases, epistaxis, fetid diarrhœa and coldness of the skin.

DIG.—Pale cloudy urine; slowness of the pulse.

GELS.—Pale face with blue rings around the eyes; mind depressed; loss of flesh.

NUX.—Foul taste in the mouth in the morning; flaccidity of the penis; increased sexual desire; continual pain in testicles; irritable, and wishing to be alone; when due to high living.

PHOS.—Weak memory; blotches on the face; frontal or occipital headache; tendency to cough.

PLAT.—Red urine, becoming turbid and depositing a red sediment. Women—excessive sexual desire; genitals excessively sensitive to the touch.

PULS.—Great sexual excitement; milky leucorrhœa with backache; menses profuse, of a blackish color.

STAPH.—Cases of long standing; imaginary fears; confused and weak memory; toothache, with caries of the teeth; deficiency of animal heat; penis relaxed, with dull and continuous pain in testicles.

SPERMATORRHŒA.

(Abnormal discharge of semen, occurring oftener than once in ten days. Cause, masturbation; sexual excesses; gonorrhœa; worms).

ALOES.—Coldness and sweat of genital organs; scrotum relaxed; sexual desire increased; tenderness of testicles.

CAMPH.—Great nervous excitability with vertigo and throbbing pains in the head; dragging in spermatic cord.

CARBO-V.—Prostration; constipation; flatulence after eating the smallest quantity of food.

CANTH.—Inability to retain the urine; coldness of the penis; insatiable desire for sexual intercourse, with discharge of blood instead of semen.

CAPS.—Sleeplessness; great sensitiveness to open air; atrophy and coldness of the genitals; morning erections; shriveling of spermatic cord.

CAUST.—Confused memory; urine contains stringy mucus; continued loss of prostatic fluid.

CINA.—When due to irritation from worms.

CHIN.—Great debility; painless diarrhœa; menses increased; canine hunger.

COLLIN.—Urine high-colored; light-colored stools; bitter taste.

CON.—Jerking pain in the teeth; teeth seem to be loose when chewing; difficult urination.

GELS.—Depression of spirits; tottering gait; emission of semen during stool; pale face, with blue rings around the eyes.

GRAPH.—Emissions involuntary, without erection; pain in the back of the neck.

LACH.—Emissions followed by sweat.

MERC.—Clammy cold sweats at night; chilliness and great sensitiveness to cold; moist tongue with great thirst; burning in the anus during and after stool; drowsiness.

NUX.—Aggravation from liquor; frequent and ineffectual desire for stool; gastric irritability; highly seasoned food or liquors aggravate the disease.

PHOS.—Anxious and irritable; easily alarmed; pains in the chest; memory impaired.

PHOS-AC.—Apathy; semen is lost on the least provocation; loss of semen during stool; black streaks before the eyes not removed by wiping them.

PULS.—Aggravated by frequent bathing; mild, gentle persons predisposed to catarrh.

SARS.—Amorous dreams; bitter taste in the mouth; pain in the back, extending down the spermatic cords; intolerable smell of the genitals.

SIL.—Burning of the feet, with sweat; perspiration of the scrotum; aching in sacrum; weakness and heaviness of the arms; melancholy.

STAPH.—Very sensitive to the least impression; discontented, low-spirited; emissions seldom awaken him; shooting pains through right testicle.

SULPH.—Emissions without erections; watery in character and excessive in amount.

Urinary Diseases.

DISEASES OF THE KIDNEY.

ACUTE RENAL HYPERAEMIA,

(ACUTE CONGESTION).

Symptoms: Frequent painless passage of small quantities of high colored concentrated urine. It contains a little blood and hence traces of albumen. There is slight fever; aching in the back; some headache and occasionally vomiting.

CHRONIC RENAL HYPERAEMIA,

(CHRONIC CONGESTION).

Symptoms: Similar to the above, but chronic and associated with disease of the heart; abundant deposit of urates; feeling of weight in the loins and dragging pain in the testicles.

ACUTE PARENCHYMATOUS NEPHRITIS,

(ACUTE BRIGHTS DISEASE).

Symptoms: Urine dark, scanty, of high specific gravity and contains casts of epithelium, free epithelial cells, free blood corpuscles and a large amount of albumen; odor that of beef tea; slight fever with thirst, nausea, vomiting and diarrhœa; later on stupor, headache and dropsy.

CHRONIC PARENCHYMATOUS NEPHRITIS,

(CHRONIC BRIGHTS DISEASE).

Symptoms: Urine usually scanty and of high specific gravity, containing granular casts with shrivelled granular epithelium, and later fatty casts. Dropsy commences in the eye-lids and face; anæmia, which is progressive; vomiting and diarrhœa; headache;

irritability of temper; weakness of memory; sleepiness; defective sight; at first functional disturbance of the heart, later hypertrophy with dilatation.

CHRONIC INTERSTITIAL NEPHRITIS,

(GRANULAR, CONTRACTED OR CIRRHOTIC KIDNEY).

Symptoms: Obscure headache; palpitation; chilliness; local paralysis; urine increased, of low specific gravity, containing a very small amount of albumen; later small granular or hyaline casts.

ALBUMINOID KIDNEY,

(LARDACEOUS KIDNEY).

Symptoms: Urine increased, of low specific gravity, containing much albumen and waxy casts; accompanies wasting diseases.

CYSTIC DEGENERATION OF THE KIDNEY.

Symptoms: Frequent passage of more or less bloody urine; failure of strength; enlargement of the kidneys can be felt through the abdominal walls as soft bodies.

PYELITIS,

(INFLAMMATION OF THE PELVIS OF THE KIDNEY).

Symptoms: Frequent painless urination, the urine containing pus and columnar epithelial cells from the pelvis of the kidney; dull aching pain over the loins. When the structure of the kidney is also affected the urine will be found to be albuminous and will contain tube casts; hectic fever.

TUBERCULAR DISEASE OF THE KIDNEY.

Symptoms: Severe pain in loins; dribbling of bloody urine; profuse night sweats.

CANCER OF THE KIDNEY.

Symptoms: Pains in lumbar region; hæmaturia and often albuminuria; enlargement of the kidney, forming a tumor which is easily recognized.

PERINEPHRITIS,

(INFLAMMATION OF TISSUE ABOUT THE KIDNEY).

Symptoms: Tenderness in the loin of one side with pain increased by motion; a fullness over the situation of the kidney, with fluctuation; urine normal.

ACUTE ATROPHY OF KIDNEY.

Symptoms: Scanty albuminous urine with deposits of casts; tendency to hemorrhages; jaundice; uræmic nervous affections.

HYDRONEPHROSIS,

(DROPSY OF THE KIDNEY).

Symptoms: Tumor in lumbar region, displacing and compressing the colon; occasionally constipation; more or less fluctuation of the tumor; may be confounded with ascites, hydatids of the kidney, and perinephritic abscess.

SYPHILITIC DISEASE OF KIDNEY.

Symptoms: Slight temporary albuminuria with other evidences of syphilis.

ALBUMINURIA.

(Albumen in the urine. Due to acute and febrile diseases, Bright's or organic disease of kidney, leucorrhœal or gleety discharges and blood).

ARSEN.—Restlessness; drinking often and little at a time; pale, puffed face.

APIS.—Thirstlessness; frequent and copious discharges of urine, or dark-colored and scanty urine; œdematous swelling of the face and extremities; gastric derangements.

ARG-NIT.—Acute or dull pains, extending from the kidneys down the ureters to the bladder, dark, dried-up or bluish countenance.

AURUM.—Melancholy mood, with desire for death; bloated, shining face; urine like butter-milk; mucus sediment; hot, red urine, containing sand.

BRY.—Irritable; aversion to motion; faintness when rising from bed.

CANTH.—Burning, stinging, tearing pains in the kidneys, extending along the ureters into the bladder; much mucus in the urine; burning in the neck of the bladder.

CUPR.—Fever in irregular fits; twitching of the limbs and biting of the tongue; excessive thirst.

COLCH.—Œdematous swelling and coldness of the feet and legs; urine dark and scanty; gouty subjects.

DIG.—Slowness of the pulse; bluish hue of the skin; alternate emissions of large and small quantities of colorless urine.

DULC.—Aggravation from taking cold, or cold weather; turbid, foul-smelling urine; micturition painful.

GELS.—During pregnancy; high fever without thirst; flushed face; sudden spasmodic pains in the abdomen.

LACH.—Urine dark, almost black, scanty; face puffed, yellowish; climacteric period; patient worse after sleeping.

LYC.—Increased secretion of a whitish, turbid, foaming urine; pain in the back previous to urination, with relief as soon as the urine begins to flow; low-spiritedness and great weariness.

SULPH.—When due to suppressed eruptions or alchoholic drinks; pains of all sorts in the small of the back.

CYSTITIS.

(Catarrh or inflammation of the bladder. Due to gonorrhœa, taking cold, irritation from calculi and morbid growths, and medicinal agents).

Acon.—Brought on by exposure to cold, dry winds, and accompanied by high fever, restlessness, thirst and burning urine of a reddish color; micturition painful, difficult, and often passed drop by drop; children place their hands on the genitals and cry out with the pain.

Arn.—When due to an injury.

Ars.—Burning pain at commencement of micturition; distension of the bladder; cloudy urine, containing pus and blood; intense thirst; anxiety and restlessness, with fear of death.

Apis.—Urine dark-colored and scanty; thirstlessness; bearing-down feeling in the bladder, with frequent desire to urinate.

Bell.—If *Acon.* has not proved beneficial; rapid sinking of strength; spasm of neck of bladder; region of bladder very sensitive to touch; urine hot and fiery-red.

Carbo-veg.—Chronic cases in old people; weakness, with coldness, chilliness, and palpitation of the heart.

Caust.—Frequent, difficult and painful urination; light-colored urine with cloudy sediment; thirst; urine loaded with lithic acid and lithates; great debility.

Canth.—Burning tenesmus and violent pains in the bladder; urine dark colored, bloody, and is passed drop by drop, with extreme pain; violent fever, with thirst, but drinking increases the pain; flushed face, often delirium, and even nausea and vomiting.

Cann.—When due to gonorrhœa; burning during and after micturition; urine red and turbid or white and turbid.

Caps.—Urine scanty and light-colored; spasmodic and cutting pains in neck of bladder; burning in urethra after urinating.

Coff.—Urine dark-brown, fetid, much mucus, some blood, hot and very

painful on passing; very nervous and restless; sleepless; cannot pass urine without catheter.

Coloc.—Thick, brown, fetid urine; alternate stitches in the bladder and rectum; frequent tenesmus; colicky pains in the abdomen.

Cupr.—After child-birth; micturition preceded, accompanied and followed by forcing pains, similar to those of labor; cold hands and feet; thirst.

Dig.—Pressure on the bladder, with a sensation as if it were too full, continuing after micturition; continual desire to urinate, only a few drops being passed at each time.

Dulc.—From taking cold; constant desire to urinate; painful micturition; urine turbid and white.

Hell.—Constant desire to urinate, with painful emission of small quantities of urine, which is turbid and dark, depositing a mucous or purulent sediment. Children cry and fret all the time.

Hyos.—Frequent urination with scanty discharge; urine yellow or turbid depositing a grayish, white sediment.

Hep.—Urine blood red or brownish red; flocculent and covered with a greasy pellicle; pus in the urine.

Lyc.—Worse from 4 to 8 p. m.; pain in small of back before urination; turbid, milky urine, depositing a thick, purulent sediment; bloody urine; foul-smelling urine.

Lach.—Feeling as of a ball rolling in the bladder, with dull pain; copious discharge of foaming urine; yellow or copious brown-red urine, depositing a brick-dust sediment.

Nit-ac.—Urine smells like that of horses; urging after micturition, with shuddering along the spine.

Nux.—After suppressed gonorrhœa or allopathic drugging, painful, ineffectual urging to urinate; discharge of urine drop by drop, with burning and tearing; spasmodic retention of urine.

Phos-ac.—Urine like milk; cramp-like constriction of the bladder, anguish and uneasiness before micturition; paleness of face; thirst; emaciation.

Puls.—Tenesmus of bladder, with painful pressure; after urinating, spasmodic pain in neck of bladder, extending to the pelvis and thighs; slimy sediment in urine.

Sarsap.—Chronic cases; much pain at the close of urination; discharge

of white, acrid, turbid matter from the urethra; severe tenesmus as in gravel.

Sep.—Chronic cases; greasy cuticle on the surface of the turbid urine; fetid urine, depositing a clay-colored sediment; during and after micturition, chilliness and heat in the head.

Sulph.—After gonorrhœa; scrofulous persons; painful discharge of bloody urine; sediment thick, tough, mucus or purulent; pain in urethra after micturition.

Thuja.—After gonorrhœa; urine clear when voided, but becomes cloudy on standing; red urine, depositing a brick-dust sediment.

Uva Ursi.—Mucus discharge mixed with blood.

DIABETES.

(Profuse flow of urine. Causation—hereditary, often.)

Ars.—Drinks often and little at a time; earthy complexion; faintness.

Arg-nit.—Desire for sweets; debility; pale but strong smelling urine.

Arg-met.—Urine greatly increased in amount and contains sugar in large quantities; œdematous swelling of feet and scrotum.

Arn.—Turbid urine, like butter-milk.

Amm-carb.—Much thirst; bitter taste in morning; desire for sugar.

Baryta-carb.—Frequent and profuse urination every other day; scrofulous persons.

Canth.—Urinates every few minutes and a large quantity at a time; rapid loss of strength.

Chel.—After drinking wine; large quantities of sugar in the urine.

Carbo-veg.—The most innocent food disagrees.

Caust.—Frequent and urgent desire to urinate in hysterical females.

Coloc.—The urine when voided is white and turbid, but after standing becomes a milk-white, jelly-like mass; pale urine, with a light brown, transparent, flocculent sediment; renal pains.

Eup. purp.—Constant urging with copious discharge, attended with aching in bladder.

Helonias.—Urine profuse, clear, light colored; over-sensitiveness to fresh air.

Kali-carb.—Violent thirst in evening and at night; sunken eyes; frequent and violent desire to urinate at night; urine of a pale, green color; feeling of cold in intestines, as if water were dropped upon them; fetid breath; irritable; surly state of mind.

Kreos.—Drowsiness with frequent yawning; no appetite; sediment red or white; cold feeling in the epigastric region.

Lyc.—Urine clear like water, or turbid; excessive thirst, especially at

night; obstinate constipation; low-spiritedness; loss of sexual power.

MERC.—Scrofulous or syphilitic persons; flabby tongue; offensive breath; great thirst; canine hunger; constant desire to urinate, with cutting pains in left kidney; faint, sickish pain in abdomen; always feel worse at night.

MOSCH.—With impotence; insatiable thirst; constipation; emaciation; sugar abundant.

MUREX.—Urine smells like valerian; discharges blood while urinating.

NATR-SULPH.—Patient is depressed, tired of life. Increased flow of urine, with burning sensation when passing it. Brick dust or whitish-yellow sediment.

NUX.—The most urine is voided at night; after allopathic drugging, or abuse of stimulants.

PHOS.—White urine with brick-dust deposit and variegated cuticle; nervous debility and trembling.

PHOS-AC.—Urine like milk mixed with jelly-like, bloody pieces, with pain in kidneys; passes large quantities of colorless urine at night; nausea and vomiting; is very indifferent.

PLUMB.—Hectic fever, with dry, hacking cough and great exhaustion; excessive emaciation; great hunger; constipation, sweetish belching and vomiting; copious red or green urine; anxiety with restlessness.

RHUS.—In rheumatic subjects.

TEREBIN.—Dull, languid feeling, relieved by micturition.

URAN.—Dyspeptic symptoms; profuse urination at night.

DYSURIA.

(Painful urination. This is the first degree of retention of urine). Consult also remedies for gonorrhœa and strangury.

Acon.—After a cold; high fever; dry, hot skin; urine pale, watery, or very dark; plethoric persons.

Arn.—After mechanical injuries; feeling of fullness in the bladder; plethoric persons with red face.

Ars.—Restlessness; exhaustion; great thirst; burning pains in bladder and urethra; urine normal or green, blue or black.

Canth.—Intense pain on urinating; violent cutting, pressing and cramping pains in bladder, extending into the urethra and kidneys; urine is mixed with blood or with pus and blood.

Camph.—After the abuse of cantharis, turpentine or other drugs.

Con.—The urine flows and stops, and flows and stops at each emission; difficult and painful urination.

Cann.—Painful jerks in the abdomen; frequent urging to urinate, with profuse flow; very difficult and painful urination.

Dulc.—From cold; getting feet wet; cold drinks.

Lyc.—During pregnancy; red sand in the urine.

Nux.—From suppression of hemorrhoids, abuse of beer or alcoholic stimulants; after allopathic drugging or hot stuffs.

Op.—When occasioned by fright or chagrin, with constipation.

Puls.—From menstrual suppression.

Phos.—Difficult and scanty urination; tall, slender persons.

Sulph.—Scrofulous subjects and those with cutaneous eruptions; great pain on urination, the urine being mixed with blood.

ENURESIS.

(Involuntary discharge of urine, incontinence of urine. Due to worms, calculus, struma, hysteria, paralysis, prostatitis and willful laziness).

ACON.—From fright or cold; hysterical women; urine pale and watery.

ALOES.—Enlarged prostate; constant urging for stool; passing small quantities.

AMM-C.—At night; pale urine with red sediment.

APIS.—Great irritation of the parts; worse at night.

ARG-NIT.—Pale, fetid urine; drinking coffee aggravates.

ARN.—Injuries; paralysis of sphincter; constant dribbling.

AUR.—Especially at night; paralysis of bladder.

BELL.—Spasmodic action of bladder; profuse perspiration; moaning during sleep.

BENZ-AC.—Urine high-colored, irritating, and smells like that of horses. (*Nit-ac.*).

CALC.—Small, fat children, who sweat easily and catch cold easily.

CAMPH.—After irritating drugs (*Canth.*, *Tereb.*, *Copaib.*, etc).

CARBO-VEG.—With acidity of the stomach.

CAUST.—Children (boys) with black hair and eyes; always during first sleep; urine loaded with lithic acid and lithates; great debility; aggravated by coughing, sneezing, etc.

CHAM.—With whooping-cough; straw-colored, watery urine.

CINA OR SANTON.—With worm symptoms and canine hunger.

DIG.—Slow pulse; palpitation of heart; vertigo.

DULC.—The result of catarrh of bladder, or cold; copious, turbid, foul-smelling urine.

FERR.—Only during the day.

Ferr-phos.—Enuresis nocturna, from weakness of the muscles, often seen in women when every cough causes the urine to spurt.

Graph.—Sour-smelling urine; scanty discharge.

Hep.—Urine passed slowly and without force; discharge of mucus from the urethra; very hasty in his actions.

Hyos.—Loss of will to urinate; or frequent scanty urination.

Kreos.—Wakes at night with urging, but cannot hold the urine only during deep sleep; strong-smelling urine.

Lyc.—Urine acid; red sand in urine; observing dispositions.

Merc-sol.—Children who perspire easily; urine hot, acrid and sour-smelling.

Merc-bin.—Cannot hold the water a moment.

Natr-mur.—Tenesmus; brick-dust sediment.

Petr.—Weakness of neck of bladder; chronic blenorrhœa; urine drops out after urination.

Puls.—Of little girls; worse in the fall.

Rhus.—Worse during rest; better from continued motion; dreams of walking, running, etc.

Ruta.—While walking and at night; greenish urine.

Sep.—Always during first sleep; (*Caust.*); those who practice masturbation; talks during sleep.

Sil.—With worms; in chorea; from blows upon the head; feet smell badly.

Staph.—Teeth decay early; fetid perspiration.

Sulph.—Pale, lean children, who dislike to be washed; twitches during sleep; obstinate cases.

Thuj.—Warty growths.

Uva Ursi.—Burning after the discharge of slimy urine; green urine; bloody urine.

HEMATURIA.

(Bloody urine. Due to gonorrhœa, affections of the bladder, kidney, ureter and urethra; abnormal conditions of the blood; malignant fevers; suppression of menses; and mental emotions).

Acon.—Plethoric persons; after a cold; high fever.

Arn.—After straining from lifting, or other injuries.

Ars.—Characteristic restlessness, thirst and burning pains.

Calc.—From getting feet wet; blood discharged in clots; putrid-smelling urine; greenish urine.

Camph.—From the abuse of Canth,. Tereb., Copaib., and other irritating drugs.

Cann.—With painful jerks in abdomen.

Canth.—Blood continually dropping from the urethra; burning pain before, during and after micturition; urethra painful to touch.

Carbo-veg.—With epistaxis, exhaustion and flatulency..

Chimaphil., Ham.—Passive hemorrhage.

Erigeron.—Urine profuse, of strong odor.

Hep.—Urine blood-red; flocculent and covered with a greasy pellicle.

Ip.—Profuse with faintness; nausea; flow of blood when not urinating; great debility.

Lyc.—Chronic catarrh or gravel; discharge of bloody coagula.

Merc.—Painless discharge during sleep; or very painful micturition, with profuse sweat.

Natr-m.—Cutting pain in the urethra after micturition. Hematuria after scurvy.

Nit-ac.—Active hematuria, urging after micturition, with shuddering along the spine; discharge of blood between the acts of micturition.

Nux.—After coffee, liquors, or allopathic drugging; suppressed hemor-

rhoids or menses; constant desire to urinate, passing but little at a time.

PHOS.—After sexual excesses; urination difficult and scanty.

PULS.—Females with discharge of dark-colored clots; burning and spasmodic pains in bladder and urethra.

SEP.—Burning and cutting in urethra; pain in small of back and region of kidneys; yellowish face.

SULPH.—Burning, stinging and spasmodic pains in the urethra; puts feet out of bed; soles burn.

TEREB.—Burning in region of kidney; tenesmus of bladder; urine black.

ZINC.—Vicarious bleeding, in consequence of suppressed menses; involuntary discharge of urine.

RETENTION OF URINE.

(Due to loss of contractility, paralysis of the bladder, etc.; pressure of womb on bladder; tumors; foreign bodies in urethra or bladder; injuries; urethritis; strictures; prostatitis; and malignant diseases.)

ACON.—From cold, particularly in children, with much crying and restlessness; high fever; stitches in the kidneys.

ARN.—With feeling of fullness in the bladder; tenesmus of neck of bladder; injuries.

ARS.—After childbirth; severe thirst and anguish.

BELL.—In pregnant women when due to over distention; from delay in urinating; in scarlet fever.

CALC.—From getting feet wet.

CAMPH.—After abuse of cantharis, turpentine, or other irritating drugs; constant pressure on bladder.

CANN.—When obstinate; blood discharged drop by drop.

CANTH.—Urine scalds, and is passed drop by drop with extreme pain; drinking increases the pains.

CARBO-VEG.—Old people, with coldness, chilliness, and palpitation of the heart.

CAUST.—Paralysis of muscular coat of the bladder; lithic acid gravel.

DULC.—From cold; getting feet wet; cold drinks.

HELL.—Cross and irritable children; will not allow any one to touch them; bladder distended; atony of bladder.

HYOS.—In acute or malignant affections; pregnant or lying-in women; delirium; much thirst.

NUX.—Urging to stool; dribbling of urine.

PULS.—Heat, redness and soreness of the vesical region; mild persons.

RHUS.—Rheumatic persons after getting wet.

SIL.—Scrofulous children suffering from worms.

SULPH.—Painful desire to urinate; if any urine is passed, it is attended with great pain and effort and is mixed with blood.

STRAM.—Bladder distended, but no pain.

STONE--CALCULUS.

(Gravel, sand. Predisposing causes: Fevers, dyspepsia, nervous exhaustion, injuries, disease of kidneys or bladder, poverty.)

ASPAR.—Gouty diathesis.

ARG-NIT.—Uric acid disappears from the urine; scanty and rare emission of dark yellow urine.

BELL.—Urine gold-colored, depositing a red sediment; nocturnal pain in bladder;, oxalic calculus.

BERB.—Pains extending from kidney to bladder, especially left side; pains extend to left testicle, which is drawn up.

CALC.—Scrofulous or chlorotic children.

CANN.—Urine turbid; strangury.

COLCH.—Gouty persons; urine scanty, brown or black; white deposit.

ERIG.—Vesical irritation from stone.

LYC.—Much red sand in the urine; chronic affections of the mucous membranes.

LITH-CARB.—Our best remedy. Dark reddish-brown deposit; pain in the ureter and spermatic cord into the testicle.

NIT-AC.—Urging after mictu ition, with shuddering along the spine; urine smells like that of horses.

NUX.—Chronic derangements of the digestive organs.

OP.—Dark, red urine, with very thick sediment; or drowsiness, with full bladder.

PETR.—Reddish, brown and fetid urine; red sediment; dark, mucous clouds in urine.

PHOS.—Broken-down constitutions from loss of fluids; old people.

PULS.—Urine retained, with redness, heat and soreness in the region of the bladder; urinary tenesmus.

SARS.—Urine scanty, slimy, flaky, clayey, sandy; intolerable smell of the genitals; much pain at the end of urination.

SEDIMENT, bloody—Acon., Sep.
bright—Nit-ac.
brown—Ambr., Crot-t., Dig.
chalky—Led., Phyt.
cheesy—Sec-cor.
clayey—Amm-m., Berb., Phos., Sars., Thuj.
dirty brown—Acon.
gray—Kali-j.
light brown—Coloc., Puls.
milky—Ant-t.
pink—Sep., Lob.
purple—Ant-t., Bov., Flu-ac.
red—Ambr., Ars., Bell., Berb., Camph., Carbo-v., Chel., Con., Creos., Graph., Lach., Led., Lyc., Mezer., Natr-m., Nit-ac., Petr., Plat., Puls., Sec-cor., Seneg., Sep., Sulph., Verat-vir.
reddish-brown—Lith-carb., Nit-ac.
white—Acon., Aloe., Alum., Bell., Benz-ac., Berb., Bry., Calc., Camph., Canth., Caps., Chin., Colch., Dig., Ferr., Graph., Hep., Ign., Nit-ac., Petr., Phos., Phyt., Sec-cor., Sep., Sulph.
yellow—Aloe., Bary., Kali-j., Lyc., Phos., Sep., Sil., Spong.

STRANGURY.

(Extreme difficulty in urinating; urine passed drop by drop, with tenesmus of neck of bladder. See also Dysuria.)

Acon.—A few drops are passed with great pain; urine dark red and cloudy.

Apis.—Dark, scanty urine, stinging pains.

Bell.—When due to over-distension; from delay in urinating.

Cannab.—Urine bloody; discharged drop by drop.

Camph.—From cantharis poisoning.

Canth.—Urine dark colored, bloody, turbid; thirst, but drinking increases the pain.

Caust.—Brought on by taking cold; burning pain.

Dig.—Thick, blood-red sediment.

Gels.—Spasmodic cases; great nervous irritation.

Hyos.—Bladder greatly distended.

Lyc.—With tympanitic distention of the abdomen; children during dentition.

Merc.—Perspiration on making the attempt to urinate; chilliness and heat alternating.

Nux.—Spasmodic cases; suppression of hemorrhoids; abuse of beer or stimulants; spasmodic contractions of the urethra; chronic irritation lower part of spine.

Op.—Sensation as if the passage were closed.

Phos.—Anxious and irritable; emaciated; tall persons with black hair and eyes; sensation as if the passage of urine was impeded.

Puls.—Due to getting wet; penis and scrotum drawn up.

Pareira.—Can only pass urine when on his knees; strong-smelling urine.

Thuj.—Violent stitches in glans.

SUPPRESSION OF URINE.

AILANTH.—With jaundice and constipation.

APIS.—Pulse almost imperceptible.

ARN.—After injuries.

ARS.—With anxiety, restlessness, thirst and rapid prostration.

BELL.—With violent delirium; jerking of the limbs; face red and hot; constipation; profuse sweat.

BIS.—Vomiting, with great prostration; paralytic weakness and weariness in right arm.

CAMPH.—Complete after cantharis and turpentine.

CALC-CARB.—Scrofulous children.

CANTH.—In yellow or typhoid fevers; chronic inflammation of kidneys.

CAUST.—With paralysis of the limbs, following diphtheria or other acute diseases.

CON.—Unusual severe pain in the kidneys at night; old men and women.

CUPR.—Alternation of convulsions with talkative delirium; bluish color of the skin.

DIG.—Scarlet fever with dropsy; bluish, doughy appearance of the swollen parts.

HYPER.—After injuries of the spine.

HYOS.—In children suffering from meningitis, scarlet fever., etc.; twitching and jerking in all the muscles of the body.

IGN. AND MOSCH.—Hysterical women.

MERC.—Great perspiration at night, but no urine.

NIT-AC.—After the abuse of mercury ; constipation.

NUX.—From lead poisoning.

PETR.—Imagining another person lies in the same bed.

PHOS.—Quick, small, thread-like pulse ; cold perspiration of the head and extremities ; great emaciation.

PHYT.—Pulse slow and feeble ; pain in the loins.

SEC-COR.—Thin, greenish stools ; pulse small, very rapid, contracted, frequently intermittent.

STRAM.—Talkative delirium ; pulse frequent and irregular.

URGING TO URINATE.

Acon.—Discharge of only a few drops of scalding hot, dark red urine ; sometimes excited by merely touching the abdomen ; children place their hands on the genitals and cry out with the pain.

Arn.—After mechanical injuries ; scanty, yellow-red urine.

Agar.—With copious emission of urine.

Anac.—With scanty discharge.

Bell.—With scanty discharge.

Bry.—With sensation as if the urine passed off spontaneously.

Creos.—In bed, with contractive pain in the vagina.

Cann.—With aching pain.

Canth.—With scanty discharge of dark or bloody urine.

Carbo-an.—Followed by voluptuous tickling in urethra.

Cham.—With anguish during micturition.

Chin.—Urging after micturition ; constipation.

Dig.—At night ; when rising, giddy and drowsy ; passes only a few drops at a time.

Gels.—Scanty discharge with tenesmus.

Hell.—With spasms.

Hyper.—At night, with vertigo in and out of bed.

Merc.—With scanty discharge of dark red urine, soon becoming turbid.

Nit-ac.—With cutting pain in abdomen.

Nux.—Painful, ineffectual desire, passing but a few drops of red, bloody urine.

Puls.—In mild, gentle women, after getting feet wet, with cutting pain during micturition.

Sabad.—Worse after passing a few drops, with drawing in the urethra and violent burning.

Sep.—With painful bearing down in pelvis.

Staph.—With the discharge of a little dark yellow urine in a thin stream, with continued dribbling after urinating.

Thuj.—With straining and scanty urine.

Uva Ursa.—With slight discharge and burning, cutting pain after.

CONDITION OF THE STREAM.

FORKED.—Arg-n., Cannab., Canth., Petr., Rhus., Thuj.

FEEBLE.—Arg-n., Cham., Chin., Creos., Merc., Op., Verat.

SLOW.—Arg-n., Amm-m., Clem., Petr., Plat., Sulph., Zinc.

SPREADING, FAN-SHAPE.—Cann.

THIN.—Bell., Camph., Clem., Graph., Merc., Nit-ac., Puls., Sars., Staph., Sulph., Thuj., Zinc.

THE STREAM is interrupted several times before the urine is entirely voided.—Con., Chin., Thuj.

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